| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 335765 | A. Building<br>B. Wing | 01/12/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Ten Broeck Commons | One Commons Drive<br>Lake Katrine, NY 12449 |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation and interview the facility did not ensure food was stored and prepared in accordance with professional standards for food service safety. Specifically, 1) unlabeled and undated foods were stored in the kitchen refrigerator and unit pantry, and eight (8) cups of pre poured undated almond milk at the bedside of Resident #160; 2) expired foods were stored in the dry pantry, walk in cooler, and reach-in refrigerator; 3) staff were observed not wearing hair and beard restraints while in the kitchen; 4) ice packs were observed in the Catskill unit pantry freezer; and 5) staff were observed not changing gloves between tasks.The findings include: The policy last revised 10/2025 titled Storage of Non-Perishable Foods documented, Dry goods (grains) shall be stored for a period not to exceed three months. All foods must be labeled and dated to ensure foods are being used in a proper timeframe, and any unopened food item will be discarded by the manufacturer labeled expiration date.The policy dated 2025 titled Storage of Perishable Goods documented, Left-over food items will be discarded after 72 hours. Food items shall be dated after opening and discarded after 72 hours or before the use by/ expiration date, whichever comes first. Any non- food items shall not be stored in refrigerator/freezer.The policy dated 2025 titled Personal Hygiene documented employees must have clean hair and worn in a manner that can be completely covered by the hair restraint.During the initial tour of the kitchen on 01/05/2026 at 9:39 AM with the Food Service Director, the following was observed:A dietary staff member not wearing a hair restraint. The main walk-in refrigerator and tray line refrigerator contained multiple racks of unlabeled and undated single serving puddings, desserts, prunes, salads, and drinks.The refrigerator contained a large carton of potato salad with a use by date of 12/02/2025 and a pan of ground macaroni salad covered in plastic wrap dated 12/20/2025. The cook's refrigerator contained thawed deli cut ham dated 12/30/2025.The dry storage room contained a pan with five (5) bags of portioned powdered rice dated 01/14/2025, clam base and ham base with no expiration dates, and an opened jug of soy sauce that required refrigeration. During an interview with the Food Service Director on 01/05/2026 during the initial tour at 9:39 AM they stated the dietary staff had just returned from break and despite being in the kitchen, did not have their hair restraint on yet. They stated the food items in refrigeration at the tray line were for production that day. They never label or date those items because they would be used that same day. They stated anything uneaten from the meal trays would be thrown out and any items left after tray line was complete at the end of the day would be dated at that time. Stock is rotated by the stocking staff person, but the disposal of expired food was everyone's responsibility.During an observation of the Catskill unit pantry on 01/05/2026 at 11:04 AM there was opened and undated prune juice in the refrigerator and four (4) medical ice packs in the freezer. Registered Nurse Unit Manager #1 was interviewed during the observation and stated the ice packs should not have been in the freezer and it was the nursing staff's responsibility to date the prune juice when it was opened. They removed the freezer packs and discarded the prune juice. During an observation and interview on 01/05/2026 at 11:23 AM there were eight (8) Styrofoam cups with lids on the bedside table of Resident #160. The cups were marked with a black letter A only, no date. Resident #160 stated they were cups of almond milk that were delivered with each meal. They had been saving the cups of<br>(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 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | almond milk to drink at their leisure. Resident #160 stated they would smell and/or taste the almond milk to determine if it was safe to drink.During an interview on 01/05/2026 at 11:34 AM, Certified Nurse Aide #2 stated they knew to discard food that had expired by looking at the date. They were aware the resident was keeping the almond milk and did not realize it was not dated. They stated the resident did not want it thrown away. They would speak with Resident #160 about discarding the undated almond milk. During an observation on 01/06/2026 at 2:00 PM two (2) kitchen staff members with beards and moustaches were observed without beard restraints while cutting raw meat and preparing sandwiches. During an interview with the Food Service Director on 01/07/2026 at 11:30 AM regarding the undated almond milk observed in Resident #160's room, they stated residents should not be storing food from their meal tray in their room and that the kitchen had no control over what was left in resident rooms. Surveyor asked about male dietary staff not wearing beard restraints. The Food Service Director stated staff with facial hair have been educated on wearing beard restraints. The Food Service Director then provided an in-service on hygiene that was completed in August 2025.During observations and interviews on 1/8/26 at 4:39 PM there were five (5) dietary staff members in the kitchen not wearing hair restraints. The Food Service Director stated the staff had just started their shift. Dietary Supervisor #11 was observed not wearing a hair restraint as they helped set hot food on the tray line. Dietary Supervisor #11 yelled for staff to put on hair restraints and put their's on too. Then Dietary Supervisor #11 was observed wearing gloves while touching a cart handle and then touched the spoon/ ladle part of serving utensils for service at tray line. They stated they realized they should have changed gloves after touching the cart handle. 10 NY CRR 415.14(h) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide and implement an infection prevention and control program.<br><br>F880 AMBased on observation, record review and interview conducted during the recertification survey, the facility did not ensure infection control prevention practices were maintained to prevent the development and transmission of communicable diseases and infection for all residents. Specifically, the annual water sampling report for the year 2025 was missing, the annual facility assessment for legionella and required components were missing and not provided at time of survey. The findings are: During a review of facility records on 01/05/2026 at 10:00 AM, a water temperature log documented chlorine was added. A vendor service report dated 11/2025 had a sticker attached that documented the water report was due 12/2024. A lab report for legionella testing was dated 11/27/2024. When requested, the Maintenance Director was unable to provide a legionella lab report for 2025, a Water Management Plan and the annual facility assessment/ Department of Health form for Environmental Assessment of Water Systems in Healthcare Settings.The facility provided a policy and procedure for Water Management that did not document control locations or control limits or prevention measures.In an interview with the Maintenance Director on 1/6/25 at approximately 1:30 PM, the Maintenance Director stated that chlorine was added to the water to prevent legionella and water sampling was scheduled for next week.10 NYCRR 415.19 |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>Based on observations, interviews, and record review conducted during the recertification survey from 1/5/2026-1/22/2026 the facility did not ensure a resident was treated with respect and dignity and cared for in a manner that promoted maintenance or enhancement of their quality of life for 1 of 1 resident (Resident #43) reviewed for Dignity. Specifically, Resident # 43 was observed out of bed wearing socks that were labeled with the resident's name in front of the sock clearly visible to other residents, visitors and staff. The findings include:Resident #43 had diagnoses including Diabetes Mellitus, Cardiomyopathy (enlarged heart, makes it harder to pump blood) and an Immunodeficiency condition.The Facility Policy titled Quality of Life dated 2025 documented residents shall always be treated with dignity and respect. The residents will be assisted in maintaining and enhancing his self-esteem and self-worth.The admission Minimum Data Set (assessment) dated 11/26/2025, documented Resident #43 had moderately impaired cognition, could usually understand others and could make himself understood. The resident was dependent on staff for lower body dressing and donning footwear.The Care Plan Titled Activity of Daily Living dated 7/11/2025 documented Resident #43 was dependent on staff daily to meet activities of daily living. The care plan documented the resident required substantial to maximal assistance with putting on and taking off footwear; and required partial to moderate assistance with lower-body dressing. During observations on 01/08/2026 at 5:02 PM and 1/9/2026 at 4:09 PM, Resident #43 was in the hallway, seated in their wheelchair, and wearing socks labeled with their name clearly visible to other residents, staff, and visitors on the top of their foot.During an interview 1/8/2026 at 3:42 PM, Certified Nurse Aide # 8 stated the socks belonging to the residents were labeled on the outside near the toe area. They stated the socks should have been labeled on the inside and not visible to visitors and staff.During an interview on 1/8/2026 at 4:17 PM, Licensed Practical # 9 stated when the family brought clothes they were sent to the laundry for labeling. They stated the socks should have been labeled on the inside, so the names were not visible to others.During an interview 1/9/2026 at 3:00 PM, the Director of Environmental Services and Maintenance stated that resident clothing was first taken to the reception desk and then sent to the laundry, where labels were created and applied. The Director of Environmental Services and Maintenance stated that shirts should be labeled on the inside near the manufacturer's tag, pants should be labeled on the rear waistband, and socks should be labeled on the back rather than on the toe area where labels may be visible. 10 NYCRR 415.5(a) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review during the recertification survey from 01/05/2026-01/12/2026, the facility did not ensure that the Comprehensive Care Plan was revised to reflect changes and/or new interventions for one (1) of six (6) residents (Resident #71) reviewed for Accidents, and one (1) of three (3) residents (Resident #139) reviewed for Activities. Specifically, 1) Resident #71 had a behavior of wandering, entering other residents' rooms and laying in other residents' beds, and the behavior care plan did not reflect this behavior or interventions for the behavior; 2) Resident #139's care plan had not been revised to reflect their current activities they participated in.The findings included:The facility policy Care Planning last reviewed 02/2025 documented that the comprehensive care plan includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. Assessments of residents are ongoing, and care plans are revised as information about the resident and the resident's condition change1)Resident #71 was admitted to the facility with diagnoses that included dementia, depression, and falls. The admission Minimum Data Set, dated [DATE] documented Resident #71 had severely impaired cognition, no behaviors including wandering, was dependent on staff for transfers, and ambulation not attempted due to medical condition and fall history. The Behavior Care Plan created on 01/06/2026 with an initiation date of 10/29/2025, documented the resident has the potential to be physically aggressive related to anger, dementia, depression, poor impulse control. The goal was the resident will demonstrate effective coping skills, will not harm self or others. Interventions included to administer medications as ordered, monitor for side effects and effectiveness, analyze times of day, places circumstances, psychiatric consult as indicated. When resident becomes agitated intervene before agitation escalates, guide away from source of distress engage calmly in conversation, if response is aggressive staff to walk calmly away and approach later. There was no documented evidence in the care plan describing Resident #71's wandering behavior, entrance into other resident rooms, or occupying other residents' beds and interventions to protect them and other residents from potential resident-resident altercations. During an observation on 01/05/2026 at 11:38 AM, Resident #71 was observed alone laying in Resident #11's bed. Licensed Practical Nurse Unit Manager #9 came to the area and stated Resident #71 often goes in other residents' rooms. During an observation on 01/07/2026 at 12:13 PM, Resident #71 was in Resident #162's room laying in their bed. Resident #162 was outside the room, appeared upset that Resident #71 was in their room and bed, and went to get staff assistance. Resident #162's verbalization was mostly unclear when speaking with staff but gestured frustration with the situation and stated clearly, all the time. Resident #162 was reassured by Licensed Practical Nurse #15 who stated they would get Certified Nurse Aide #16 who would convince Resident #71 to get out of their bed. During an interview on 01/12/2026 at 10:32 AM, Licensed Practical Nurse Unit Manager #9 stated that Resident #71 does wander on the unit and does go into other residents' rooms. This specific behavior is not in the care plan but agreed it should be. They are responsible for reviewing the care plans for accuracy. They then collaborate with a Registered Nurse, and the Registered Nurse updates the care plan. 2) Resident #139 was admitted with diagnoses that included Alzheimer's Disease, major depressive disorder, and anemia.The Annual Minimum Data Set, dated [DATE] documented severely impaired cognition, no behaviors, moderate assistance required with eating, dependent on assistance for all other activities of daily living.During an observation on 01/05/2026 at 12:25 PM, Resident #139 was sitting in a wheelchair/recliner in common area, spouse visiting.During an observation on 01/06/2026 at 11:48 AM, Resident #139 was sitting up in recliner in the unit common area, spouse visiting. An activity recently ended but resident had not actively participated.During an observation on 01/07/2026 at 10:35 AM, Resident #139 was sitting up in a<br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | recliner in the unit common area, resting with eyes closed, music playing.The Activities Care Plan dated 2/15/22 documented that resident had a sense of humor and was dependent on staff for assistance. A biography followed with preferences they had in the past prior to admission. The goal dated 08/16/2023 documented that resident will maintain physical, cognitive and social skills by participating in activities of her capabilities and interests such as movie day. The interventions, last revised 5/2/22, documented that staff will ensure activities are those of her capability and interest. Monthly calendar will be provided.During an interview on 01/08/2026 at 9:30 AM, the Activities Director stated that they reviewed all the activities care plans and was responsible for updating them quarterly and as needed. The activities staff directly involved with the resident on the unit may update as well. They stated that Resident #139's spouse came every day and that was their main activity. Otherwise, they provide one to one visits. Resident #139 also sits in the unit common area and watches the lucynt table (a table that projects images on it), will participate with fidgets, and attend socials and worship service. They had not revised the care plan to reflect the spouse visits and other activities described but could add them.During an interview on 01/09/2026 at 9:40 AM Activities Leader #17 stated Resident #139 enjoys music, they read chronicles to them, perform manipulatives at the table, and enjoys hand massages. They stated they did not attend the care plan meetings. They could review and edit the care plans, but really the Activities Director handles the care plans. They were focused on performing the activities on the unit with the residents. During an interview on 01/12/2026 at 2:31PM, the Director of Nursing stated that care plan updates were quarterly, annually, and as needed. If there was a change between care plan meetings, they would expect that to be completed. Registered Nurse Unit Managers complete the care plans, Licensed Practical Nurse Unit Managers work with a Registered Nurse to complete the care plans. The activities care plan should be completed by the Activities Director. The nutrition care plan was completed by Dietary, and the Social Worker was responsible for the advanced directives care plan. NYCRR 415.11(c)(2)(i-iii) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview conducted during a recertification survey, the facility did not ensure that care was provided to prevent pressure ulcers for 1 of 5 residents (#9) reviewed for pressure ulcers. Specifically, Resident #9 had a physician order for offloading gel boots, to be worn at all times, and was observed without the gel boots. The findings include: Resident #9 had diagnoses including Cerebral Infarction, Type 2 diabetes mellitus, hemiplegia. The Quarterly Minimum Data Set, dated [DATE] documented the resident's cognition was intact, the resident required substantial to max assist with all activities of daily living. The resident was at risk for pressure ulcers and pressure relieving devices for both the chair and bed were used. A Braden Scale assessment completed on 12/15/2025 documented a score of 16 indicating the resident was at risk for pressure injuries. The Care Plan titled At Risk for Skin Breakdown dated 8/27/2025, revised 12/9/2025, documented interventions included the physician would be notified for skin breakdown, and to do weekly skin observations. The Care Plan Activities of Daily Living dated 8/27/2025, documented the resident wore gel boots at all times. The Physician Order dated 12/23/2025 documented gel boots to bilateral feet at all times. Licensed Practical Nurse #4' progress note dated 12/23/2025, documented the resident complained of tenderness to right heel and the right heel had blanchable redness. The left lateral foot near metatarsal had blanchable redness. Gel boots were applied to both feet. During an observation on 01/05/2026 at 12:23 PM the resident was positioned in a Geri chair, socks on both feet and the gel boots were not in use. The resident's heels were pressing against the footrest. During an observation on 01/07/2026 at 9:42 AM the resident was out of bed in a Geri chair positioned with a black wedge to the left and a pillow under their left arm. The resident's feet were in socks, and they did not have gel boots on. During an interview on 01/07/2026 at 11:42 AM, Resident #9 stated they wanted to wear the off-loading boots, and the staff had not been putting them on them. During an observation on 01/07/2026 at 11:55 AM, Resident #9 was in the dining room, in the Geri Chair, and was not wearing gel boots. The resident's heels were pressed against the footrest of the Geri Chair. During an interview on 1/7/2026 at 12:00 PM, Licensed Practical Nurse #4 stated Resident #9 had a reddened area to their left heel. The resident should have been wearing the pink boots to offload their heels. They stated the resident had a stroke, and the left side was paralyzed which put them at risk for skin break down. During an interview on 01/07/2026 at 11:44 AM Certified Nurse Aide #3 stated they thought the resident only needed the boots while in bed. During an interview on 01/09/2026 at 10:12 AM the wound nurse stated the staff reported the resident heels were red, and gel boots were ordered for the resident. When the wound team looked at the heels, they were not red, and the order for the gel boots was continued for prevention. The resident should have been wearing the gel boots at all times. The resident was at risk for developing skin breakdown of the heels related to the history of a stroke and a left hemiplegia (weakness). During an interview on 01/09/2026 at 2:59 PM the Director of Nursing stated the resident had a physician order for gel boots and it was care planned in the Activities of Daily Living Care Plan. The resident should have been wearing the gel boots and if they were unavailable, at a minimum, the heels should have been offloaded. 415.12(c)(1) |

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| F 0814<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Dispose of garbage and refuse properly.<br><br>Based on observation, record review and interview during the recertification survey conducted 01/05/2026 through 01/12/2026, the facility did not ensure proper disposal of garbage and refuse. Specifically, the garbage/recycle dumpster was left open and there were cardboard boxes spilling over the top and debris on the ground around the dumpster.The findings are:The facility policy titled Disposal of Refuse reviewed 12/2025 documented outside dumpsters or compactors provided by waste management services will be kept closed and free of surrounding debris.During an observation of the garbage area on 01/05/2026 at 11:39 AM with the Food Service Director, the recycle dumpster lid was open with cardboard boxes spilling over the top; pieces of cardboard box; used gloves; plastic packing material; and plastic drink lids laying on the ground surrounding the dumpster.During an interview with the Food Service Director on 01/05/2026 at 11:39 AM, they stated the garbage and recycle is picked up once weekly. They do not think the lid to the recycle dumpster is ever closed, and stated, it is too high for anyone to reach it to close.During a follow up observation of the garbage area on 01/08/2026 at 4:36 PM the recycle dumpster lid remained open, no debris surrounding the area. During an interview on 01/12/2026 at 9:51 AM, the Director of Maintenance stated the door to the recycle dumpster should be closed per the facility policy. They stated maybe kitchen staff did not close the lid because it has been cold, and staff didn't want to stay out in the cold. They will provide education to the kitchen staff since they are the last to use the dumpsters each day. 10 NYCRR 415.14(h) |