

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335766	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Ghent Rehabilitation & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Whittier Way Ghent, NY 12075	
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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews conducted during a survey, the facility did not ensure residents were provided food and drink that was palatable, flavorful, and at an appetizing temperature. Specifically, (a) for Resident #31, food was not served at an appetizing temperature during a lunch meal on 07/21/2026 and stated that food was cold; (b) for Residents #37, #50, and #3, food was not served at an appetizing temperature and/or palatable; and (c) six anonymous residents during a resident council meeting on 07/16/2026 stated the food was not that good, often cold, and was undercooked. Findings include: Facility Policy titled, Food and Nutrition Services, last reviewed on 12/01/2026, documented that each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. Food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident, the food appears palatable and attractive, and it is served at a safe and appetizing temperature. If an incorrect meal is provided to a resident, or a meal does not appear palatable, nursing staff will report it to the Food Service Manager/Designee so that a new food tray can be issued. Facility Policy titled, Reheating Foods, revised on 04/2026, documented that employees will reheat food in a manner that complies with safe food handling practices. To take temperatures, a clean, rinsed, sanitized, and air-dried thermometer numerically scaled and accurate to plus or minus two degrees Fahrenheit is needed. A thermometer will be available for use as needed on the unit for reheating of food. Resident #31 Resident #31 was admitted to the facility with the diagnoses of osteoarthritis of the left hip (a type of arthritis that occurs when flexible tissue at the ends of bones wears down), congestive heart failure (a weakness of the heart that leads to a buildup of fluid in the lungs and surrounding body tissues), and hypokalemia (deficiency of potassium in the bloodstream). The Minimum Data Set (an assessment tool) dated 06/25/2026, documented the resident understood others, was able to be understood, and was cognitively intact. During an observation on 07/21/2026 at 1:30 PM, Resident #31's lunch meal was delivered and contained the following items with temperatures measured as follows: Apple juice was 66.7 degrees Fahrenheit, whole milk was 61.7 degrees Fahrenheit, blushing pears were 67.4 degrees Fahrenheit, tuna salad sandwich was 65.4 degrees Fahrenheit, and Shepard's pie was 104 degrees Fahrenheit. After tasting the food and drinks, the temperature of the entree was lukewarm to slightly cool and tasted bland; the apple juice, milk, and tuna fish sandwich were room temperature to slightly cool. During an interview on 07/20/2026 at 9:46 AM, Resident #31 stated the beef stew last night was cold. During an interview on 07/21/2026 at 9:19 AM, Resident #31 stated that if the temperatures of the food were very undesirable, they may not eat the food. For example, they received buttered zucchini in the past, and it was cold, so they did not eat it. Resident #37 Resident #37 was admitted to the facility with diagnoses of type two diabetes (a chronic condition that happens when a person has persistently high (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: 335766	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Ghent Rehabilitation & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Whittier Way Ghent, NY 12075	
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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	blood sugar levels), major depressive disorder (a mental condition characterized by a persistently depressed mood and long-term loss of pleasure or interest in life), and severe protein-calorie malnutrition (a condition caused by inadequate intake or absorption of protein and calories). The Minimum Data Set, dated [DATE], documented the resident understood others, was able to be understood, and was cognitively intact. During an interview on 07/15/2026 at 10:37 AM, Resident #37 stated the food is not appealing, and hot foods are not hot. Resident #50 Resident #50 was admitted to the facility with diagnoses of hypertension (high blood pressure), diabetes mellitus (a chronic condition that happens when a person has persistently high blood sugar levels), and depression (mood disorder that causes a persistent feeling of sadness and loss of interest). The Minimum Data Set, dated [DATE], documented the resident understood others, was able to be understood, and had moderate cognitive impairment. During an interview on 07/15/2026 at 11:34 AM, Resident #50 stated the food is cold and some of the meat is hard. Resident #50 receives ground meat, so it is easier for them to chew per their request. Resident #3 Resident #3 was admitted to the facility with diagnoses of heart failure (a condition in which the heart muscle cannot pump enough blood to meet the body's need for blood and oxygen), type two diabetes (a chronic condition that happens when a person has persistently high blood sugar levels), and protein-calorie malnutrition (a condition caused by inadequate intake or absorption of protein and calories). The Minimum Data Set, dated [DATE], documented the resident understood others, was able to be understood, and was cognitively intact. During an interview on 07/22/2026 at 9:40 AM, Resident #3 stated the food at the facility is always cold. Resident #3 stated they have to ask for a sandwich or for more food at dinner time because they are still hungry after eating the dinner meal. During a surveyor-led resident council meeting on 07/16/2026 at 10:05 AM, six out of six residents stated and agreed that the food was not that good, often cold, and were served undercooked burgers at times. During an interview on 07/21/2026 at 10:19 AM, Certified Nursing Aide #3 stated they would call the kitchen for a new tray if a resident complained about undesirable food temperatures. During an interview on 07/22/2026 at 10:35 AM, Certified Nursing Aide #5 stated the only food complaints they receive from residents are about the food being cold. Certified Nursing Aide #5 stated they would heat the food up in the microwave if a resident had complaints about food being cold. They do not take temperatures of the food after microwaving the meal. Certified Nursing Aide #5 stated it is not often that they have to re-heat a meal in the microwave. They stated that most residents who complain about undesirable food temperatures will still eat the cold food and do not ask for it to be re-heated. During an interview on 07/21/2026 at 10:50 AM, Clinical Nutrition Director #1 stated residents had complaints about food being lukewarm. Clinical Nutrition Director #1 stated that ideally, if food was being re-heated, Certified Nursing Aides should take temperatures of the food. They stated if residents are not happy with meal temperatures, staff will provide residents with a new tray. 10 New York Code of Rules and Regulations 415.14(d)(1)(2)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335766	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Ghent Rehabilitation & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Whittier Way Ghent, NY 12075	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interview conducted during the survey, the facility failed to implement and maintain an effective infection prevention and control program, by failing to ensure Contact Precautions were implemented and maintained for one resident (Resident #28) with a draining wound. Specifically, on 07/17/2026 Resident #28 who was on Contact Precautions, was observed seated in a wheelchair at a table in the dining area with another resident while the resident's wound dressing was visibly leaking drainage. Staff were observed in the area, and no redirection or interventions attempted to address the situation. The surveyor informed the Infection Preventionist who spoke with the resident, the resident was cooperative and headed back to their room for a dressing change to be performed. This deficient practice created potential for transmission of infectious organisms to residents, staff, and visitors. Findings include: The Facility's Policy and Procedure titled Isolation- Categories of Transmission Based Precautions last updated 7/2025, documented Contact Precautions may be implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. The individual on contact precautions will be placed in a private room if possible. If a private room is not available, the Infection Preventionist will assess various risks associated with other resident placement options. When transporting individuals with skin lesions, excretions, secretions, or drainage that is difficult to contain, contact precautions will be taken during resident transport to minimize the risk of transmission. Resident #28 is a [AGE] year-old, admitted to the facility with diagnosis of Schizophrenia (chronic mental health illness), Cerebral Infarct (type of stroke caused by sudden interruption of blood flow), Atrial Fibrillation (a heart rhythm disorder). The Minimum Data Set (an assessment tool) dated 6/26/2026 documented the resident is cognitively intact, makes self-understood and understands others. The Physician's Orders dated 07/02/2026 documented an order for contact precautions every shift for MRSA (Methicillin Resistant Staphylococcus Aureus) (a type of bacteria that causes skin infections and is resistant to many antibiotics) of the bilateral lower extremity. The Comprehensive Care Plan was reviewed and documented the resident was on contact precautions with an initiation date of 7/17/2026. The care plan lacked a focus and intervention. The Infection Care Plan undated documented the resident has an infection of the bilateral lower extremity wounds/cellulitis, interventions included (6/18/2026) administer antibiotics per medical doctor orders, maintain universal precautions with providing resident care. The at Risk For Skin Impairment Care Plan documented maintain contact precautions (07/02/2026). The At Risk for Skin Issues Care Plan dated 6/13/2026 documented bilateral lower extremity cellulitis with antibiotic therapy. During a resident observation on 7/17/2026 Resident #28 was observed to be seated at a table with a peer, the resident's right leg was observed to have drainage leaking from it. Staff were observed in the area and no attempts were made to redirect the resident back to their room. The Infection Preventionist was notified by the surveyor, observed the resident and stated they should not be out of their room because the drainage is leaking from the bandage. The resident was easily redirected back to their room. During interview 07/20/2026 12:18 PM Infection Preventionist nurse they stated residents on contact precautions can come out of their room if the affected area is covered and not draining. They further stated, Resident # 28 wound was draining, therefore they should not have come out of their room and that was the reason for being on contact precautions. The Infection Preventionist stated the resident would refuse to stay in his room. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335766	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Ghent Rehabilitation & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Whittier Way Ghent, NY 12075	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/21/2026 3:17 PM the Director of Nursing stated when a resident is on contact precautions they can come out of their room if the affected area is covered. If there was no drainage, then the resident can come out of their room. If there is drainage coming out of the dressing the resident would have to stay in their room. 10 New York Codes, Rules, and Regulations 415.19^^		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335766	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Ghent Rehabilitation & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Whittier Way Ghent, NY 12075	
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	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on observation, interview, and record review conducted during survey, the facility failed to ensure the resident and/or resident representative were notified of a change for one resident, Resident #111. Specifically, Resident #111 and their resident representative were not notified when one of their pain medications was discontinued, then restarted two days later as needed. The findings include: The facility policy titled Change in Status Notification revised 11/2025, documented the resident's attending physician, or designee and responsible party would be notified by the nurse manager, nursing supervisor/designee when: 1.) there was an incident or accident involving the resident; 2.) there was a sudden or unexpected change or deterioration in the resident's physical, mental, or psychosocial/emotional status; and 3.) any situation which required a change in the resident's plan of care, medication or treatment regimen. Resident #111 Resident #111 was admitted to the facility with diagnoses of osteonecrosis (the death of bone tissue caused by a loss of blood supply), furuncle of buttock (a painful, pus-filled skin infection that starts deep in a hair follicle on the rear), and congestive heart failure (a weakened heart condition that causes fluid buildup in the feet, arms, lungs, and other organs). The Minimum Data Set (an assessment tool) dated 06/19/2026, documented the resident was cognitively intact, could be understood, and could understand others. During an interview on 07/15/2026 at 12:12 PM, Resident #111 stated they were in a lot of pain. They stated they could not eat when they were in pain at times. They stated their left leg was a bad leg. They further stated they sometimes received Tylenol which did not do anything. During an interview on 07/17/2026 at 12:36 PM, Resident #111 stated they were trying not to think about the pain. Resident #111 stated they could not get any other pills for the pain but did not know why. They stated their left leg had pain because they did not have a hip and they were waiting for surgery. During an interview on 07/21/2026 at 9:44 AM, Resident #111 stated they had a bad night and were in a lot of pain. They stated they received some Tylenol, but they were not aware of any other as-needed pain medications available to them. They stated they were aware that they had received tramadol before but were not sure what it was for. Review of Resident #111's Medication Administration Record for July 2026, documented: A physician order dated 06/05/2026, tramadol tablet 50 milligram, give 1 tablet by mouth 4 times a day for chronic pain to hip. Order was discontinued on 07/14/2026 at 12:16 PM. A physician order dated 07/16/2026, documented tramadol tablet 50 milligrams, give 1 tablet by mouth every 6 hours as needed for moderate to severe pain for 14 days. There was no documented evidence that Resident #111 and/or their resident representative was notified that the resident's scheduled tramadol was discontinued on 07/14/2026 and as-needed tramadol started on 07/16/2026. During an interview on 07/21/2026 at 10:05 AM, Licensed Practical Nurse #1 stated they were not sure why Resident #111's scheduled tramadol was discontinued and a day later they started as needed tramadol. They stated maybe their pain was not as bad as it was. They also stated that when it was scheduled sometimes the resident would not need it. Licensed Practical Nurse #1 stated residents or their representative should be made aware when there were medication changes and provided an explanation as to why the medication was changed. During an interview on 07/21/2026 at 10:39 AM, Registered Nurse #2 stated Resident #111 had pain. They stated the resident had both scheduled pain medications and as-needed pain medications. Registered Nurse #2 stated they were not sure why Resident #111's scheduled tramadol was discontinued. They stated maybe it was discontinued related to the resident's constipation (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335766	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Ghent Rehabilitation & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Whittier Way Ghent, NY 12075	
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	or maybe it was not on her discharge summary when the resident returned from the hospital. Registered Nurse #2 stated normally the resident or family would be notified if there was a change in a resident's pain medication either by nursing or the provider. During an interview on 07/22/2026 at 10:45 AM, Registered Nurse #1 stated they were not sure why Resident #111's tramadol was discontinued. They stated the resident was always in pain. They stated now the resident's tramadol was as needed. Registered Nurse #2 stated if they noticed a resident had a new order, they usually reiterated it to the resident, just in case. During an interview on 07/22/2026 at 12:43 PM, Registered Nurse #2 stated they spoke with the Medical Provider and were informed that Resident #111's scheduled tramadol was discontinued on 07/14/2026 related to the resident having a possible ileus (a medical condition where the intestines stop working correctly, without physical blockage). They stated the resident went to the hospital, came back, and a nurse that knew Resident #111 was previously on Tramadol contacted the Medical Provider on 07/16/2026 and the Medical Provider said the resident should be on as-needed tramadol and put the order in. They stated the Medical Provider talked with the resident about discontinuing the tramadol and said it should be in their note. Registered Nurse #2 stated the resident was now aware the tramadol was available as-needed and had been asking for it. During an interview on 07/22/2026 at 12:36 PM, Director of Nursing #1 stated the Nurse Practitioner discontinued Resident #111's scheduled tramadol on 07/14/2026 and the as needed tramadol was started on 07/16/2026. They stated they thought it was discontinued because the resident had a possible obstruction and was sent to the hospital. They stated Resident #111's son was very involved in their care and knew everything that went on with the resident. They stated Resident #111's son was notified of their change in condition and hospital transfer, but there was no documentation about them being notified of resident's medication change. 10 New York Code Rules and Regulation 415.3(f)(2)(ii)(c)		