STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335789	A. Building B. Wing	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Taconic Rehabilitation and Nursing at Hopewell	3 Summit Court Fishkill, NY 12524

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 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, record review, and interviews conducted during an abbreviated survey (NY00359790/623106), the facility did not ensure that the residents had a right to a safe, clean, comfortable, and homelike environment, including housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior for 5 (Resident #5, #6, #7, #8 and #9) of 9 residents rooms observed for environmental concerns. Specifically, 1) In room [ROOM NUMBER]B of the Roosevelt unit, occupied by Resident #5, a new admit, the window was observed to have gray duct tape covering the entire bottom width of the windowsill. The window screen contained multiple ripped holes of varying sizes, several spackle paste were noted on the wall behind the Resident's bed, and the dresser drawer was broken and unable to close; 2) In room [ROOM NUMBER] B on the Roosevelt unit, occupied by Resident #6, the window was entirely covered with plastic and white patches of spackle were observed on the wall behind the Resident's bed; 3) In room [ROOM NUMBER] A on the Roosevelt unit, occupied by Resident #7, a new admission, multiple white patches of spackling compound were observed on the wall behind the Resident's bed and the lower portion of the walls around the bed was scratched and had scuff; 4) In room [ROOM NUMBER]A on the Roosevelt unit, occupied by Resident #8, multiple white patches of spackle were observed on the wall behind the Resident's bed; 5) In room [ROOM NUMBER]B on the Roosevelt unit, occupied by Resident #9, multiple white patches of spackle were observed on the wall behind the Resident's bed. The findings include:The facility policy titled Maintenance revised on 10/2024 documented that the facility provides an environment that fosters a positive self-image for the Resident and preserves his or her human dignity. The entire facility including, but not limited to, the floors, walls, doors, windows, ceilings, lighting, furnishings and equipment shall be maintained in good repair. Windows are checked by Maintenance. Windows that are broken or separated from the frame or otherwise not functioning as designed will be repaired or replaced. Maintenance is responsible for maintaining all the wall coverings. Supplies of the various paints, wallpapers and supplies are kept in stock.During an observation on 08/14/2025 at 11:39 am, room [ROOM NUMBER] B of the Roosevelt unit, occupied by Resident #5, the following were noted: The window had gray duct tape along the entire bottom of the windowsill, the window screen contained multiple holes of varying sizes, several spackled patches were visible on the wall behind the Resident's bed, and the dresser drawer was broken and would not close. During an interview on 08/14/2025 at 11:40 AM, Resident #5 stated that they were recently admitted a few days prior to the day of the onsite visit and was placed in the room in the current condition. The resident and family requested that the window be repaired, the patches of spackle removed, and the dresser fixed so that they could store their clothing without them being visible. Resident #5 stated that they preferred a different room, noting that the current room appeared damaged and that they would have raised concerns prior to admission had they known the condition of the room.During an observation on 08/14/2025 at 11:54 AM, room [ROOM NUMBER] B of the Roosevelt unit, occupied by Resident #6, the following were noted: plastic covered the entire window and patches of spackle were noted behind the resident's bed. During an interview 08/14/2025 at 11:55 AM, Resident #6 stated that they've been in the current room for over two months. When they first got into the room, they complained that there was a draft coming in and the room was very cold. Resident #6 stated that Maintenance initially put up duct tape, but the duct tape wasn't working, and then they came and placed a plastic covering, which has now been up for over a month. Resident #6 stated that even with the plastic covering, they could still feel the draft. When it rains, water gets trapped behind the plastic and water starts coming in through the window. Resident #6 stated that the patches of spackle behind their bed has been that way since they removed white boxes that was on the wall, and they never came back to sand or paint. During an observation on 08/14/2025 at 12:00 PM, room [ROOM NUMBER] A, occupied by Resident #7, a new admission to the facility, the following was noted: spackled patches on the wall behind the bed and the lower portions of the walls surrounding the bed and their side of the room, was dirty with scuff.During an interview on 08/14/2025 at 12:01 PM, Resident #7 stated they were admitted to the facility the day prior to the onsite visit. They were placed in the room in the current condition. Resident #7 stated that when spackle is applied to the wall and not painted promptly, the outer layer begins to flake and fall, creating dust. Resident #7 expressed concern that the spackle dust could spread throughout the room causing a safety hazard. Resident #7 stated that they would like their room cleaned, noting that the lower portions of the walls were very dirty.During an observation on 08/14/2025 at

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interviews conducted during an abbreviated survey (NY00348484/623066), the facility did not ensure residents received quality of care in accordance with professional standards of practice for 1 (Resident #4) of 4 residents reviewed. Specifically, Resident #4 had an unwitnessed fall on 03/24/2024 which resulted in a pelvic and iliac crest fracture. The hospital discharge instructions documented for Resident #4 to be non-weight bearing to the right lower extremity and to follow up with the orthopedic surgeon in 2-4 weeks. The facility was unable to provide documented evidence that Resident #4's follow-up appointment with the orthopedic surgeon as per the hospital physician's discharge instructions was done.The findings include:The facility policy titled Process for Scheduling Outside Appointments revised on 11/2024 documented that the facility will assist the resident in gaining access to specialty providers per their preference and per provider recommendation when needed for the resident's health and wellbeing. Resident #4 had diagnoses including but not limited to dementia, multiple fractures, nontraumatic intracerebral hemorrhage, and repeated falls.The 05/24/2024 Quarterly Minimum Data Set documented that Resident #4 had severely impaired cognition. The Resident required maximal assistance with bed mobility and toilet transfers and was dependent with chair and bed transfers. The 03/24/2024 Accident and Incident Report documented Resident #4 was found in the bathroom doorway laying on their right side. Resident had pain in their groin and was sent to the hospital for head trauma and pelvic and groin pain.The 03/24/2024 at 8:50 PM Nursing Progress note documented that Resident #4 was sent to the hospital status post fall and was admitted with diagnosis of pelvic and iliac crest fractures.The 03/27/2024 Hospital Discharge Summary documented that Resident #4 is to be non-weight bearing status to the right lower extremities and to follow up with the orthopedic surgeon in 2-4 weeks.During an interview on 08/14/2025 at 4:04 PM, the complainant stated that approximately one month after Resident #4's readmittance back to the facility status post pelvic and iliac crest fracture, they requested that Resident #4 be seen by the orthopedic surgeon as per their discharge instructions to follow up with the surgeon in 2-4 weeks, so that they could be cleared from to weight bear and be discharged home. They were informed that the family had to provide their own transportation for the follow up appointment to the orthopedic surgeon.During an interview on 08/14/2025 at 4:36 PM, the Director of Social Services stated that during a Care Plan meeting it was discussed that Resident #4 needed an appointment with the orthopedic surgeon and that the complainant did not want to pay for their own transportation. The Director of Social Services was unable to provide documented evidence of the discussion held during the care plan meeting concerning the transportation for the follow up appointment to the orthopedic surgeon. There was no evidence of any follow up communication with the complainant.During an interview on 08/15/2025 at 4:37 PM, the Director of Therapy stated that Resident #4 sustained a fracture and was non weight bearing on the right lower extremity, and that they asked the family what they want the facility to do, the family did not want Resident #4 to go to Westchester because of the cost of the ambulette. The Director of Therapy stated that they told the family that they would do them a favor and contact an orthopedic surgeon that they know of but was unable to provide a date or time of when they contacted orthopedic surgeon from Mid-[NAME] Regional and arranged a telehealth consultation. When documentation was requested, the Director of Therapy stated they did not write a progress note because they are a man of their word and thought they were doing the right thing by assisting nursing in getting Resident #4 an orthopedic surgeon appointment. The Director of Therapy stated that when residents return from the hospital, the unit manager and and/or unit secretary are responsible to make all follow up appointments. There was no documentation of the telehealth consultation. The Facility did not provide documentation for the date of the follow up orthopedic appointment as per the discharge instructions. During an interview on 08/14/2025 at 5:09 PM, the Director of Nursing stated that the unit manager is supposed to review all discharge paperwork when Residents are admitted and communicate follow up appointments with the unit clerk, and that the unit clerk that was responsible for making appointments. The unit clerk was no longer working in the facility. The Director of Nursing was unable to provide Orthopedic consults, orthopedic appointment progress notes, or any for follow up orthopedic appointment correspondences, when requested. 10NYCRR415.12

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on record review and interviews conducted during an abbreviated Survey (NY00380249/623119, NY00382698/623133), the facility did not ensure that Certified Nurse Aides had the appropriate competencies and skills sets necessary to care for residents' needs, and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments, and described in the plan of care. Specifically, 1) Certified Nurse Aide #1 was involved in an allegation of abuse on 05/07/2025. Review of their employee file revealed Certified Nurse Aide #1's required abuse training was last completed on 06/19/2025. Prior to that, the last abuse training was completed on 03/14/2024. 2)Certified Nurse Aide # 2 who was involved in an allegation of abuse on 5/3/2025 had their required training for abuse prevention and compliance on 05/20/2025. Prior to this, their last abuse training was completed on 02/16/2024.3) Certified Nurse Aide # 3 had their required training for abuse prevention and compliance on 05/22/2025. Prior to this date the last abuse training was completed on 04/17/2024.The findings included: The facility policy titled Abuse Prohibition last revised on 2/2023 documented that the facility's abuse prevention/intervention program includes but is not necessarily limited to regularly scheduling in-service training programs designed to teach staff how to better understand the resident's abusive actions. The policy did not include the frequency of or indicate that trainings are to be done annually. During an interview on 7/31/25 at 2:19 PM, the Staffing Educator stated that mandatory educations for staff are located on the SNF clinic (a training program and resources for nurses and caregivers in skilled nursing facilities). Staff is required to complete these trainings via computer. The Staffing Educator stated Certified Nurse Aides #1, #2, and #3 were overdue and out of compliance with completing their required training for abuse prevention and compliance and that they along with facility staff should have received several messages to complete the in-services when they were due. Notifications are also sent out through the system if their trainings are due or overdue. The Staffing Educator stated that Certified Nurse Aide #1 was assigned Abuse training on 02/01/2025 and did not. until 06/19/2025 and prior to that their last abuse training was completed on 03/14/2024. Certified Nurse Aide #2 was assigned Abuse training on 02/01/2025 and did not complete it until 05/20/2025 and prior to that, their last Abuse training was completed on 02/16/2024 and Certified Nurse Aide #3 was assigned Abuse training on 02/01/2025 and did not complete it until 05/22/2025 and prior to that, Certified nurse Aide #3's last Abuse training was completed on 4/17/2024. All three Certified Nurse Aides were out of compliance as per the requirements to complete their annual abuse trainings. The Staffing Educator stated an email is sent to the administrative team to notify them of who was out of compliance. In addition, notices are created and posted by the time clock reminding staff to complete the required annual trainings. During an interview on 07/31/2025 at 2:51 PM, the Regional Director of Nursing stated that the Staff Educator notified them earlier in the week that there are multiple staff who's required Inservice trainings have not been completed, and that it would be discussed with the team the best way to get staff to complete the required trainings. During an interview on 07/31/2025 at 3:17 PM, the Interim Administrator stated that they are aware that staff are not completing their required Inservice trainings when they are due. They plan to hold a meeting with staff and ask them to do the in-services/trainings or remove them from the schedule. During an interview on 07/31/2025 at 3:36 PM, the Director of Nursing stated that they are trying to address the staff's noncompliance of trainings/in-services with the administrative team. The Staff Educator puts out notices and does their best to reach staff to complete in-services, and they do that alone. The Director of Nursing. stated that they have decided that for the actions to be effective, they need to get involved and assist with getting in-services completed. The Director of Nursing stated that in 2 weeks the Staff Educator will no longer conduct the Certified Nurse Aide Class and will only focus on staff in services. All staff removed from duty due to an incident must be retrained. During an interview on 07/31/2025 at 12:56 PM, Certified Nurse Aide #1 stated that they do not remember the last time that they had abuse training and that trainings are done on the computer, and they have never received any disciplinary actions for not completing their trainings when they are due. Attempted to reach Certified Nurse Aide #3 on 08/01/2025 at 03:07 PM and was unsuccessful. Voice message was left. 10 NYCRR 415.26(c)(1)(iv)