

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335789	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER Taconic Rehabilitation and Nursing at Hopewell		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews during an abbreviated survey (NY00341591), the facility did not have a comprehensive patient centered care plan developed or implemented for 1 (Resident #1) out of three residents reviewed for care planning. Specifically, Resident #1 was admitted to the facility from a local hospital on [DATE] and when they came into the facility, they already had Hospice care in place from the hospital. Review of Resident #1's care plan revealed they did not have a Hospice care plan in place. The facility's policy titled Hospice Services with a revision date of 07/2025 documents that the resident and family participate in developing the care plan where appropriate and that nursing coordinates the plan of care and ongoing collaboration and communication closely with Hospice, the resident and family, and other disciplines. The facility policy titled Interdisciplinary Care Planning last revised 04/15/2024 documented that a comprehensive resident-centered Care Plan is developed by the Interdisciplinary Team upon admission and reviewed/updated on a regular basis throughout the resident's length of stay. Review of the electronic medical record for Resident #1 shows there were no orders for Hospice, there were no progress notes from any medical provider indicating that they were collaborating with the Hospice facility, and there were no care plans that indicate that the facility had a comprehensive resident-centered care plan developed regarding Hospice for Resident #1. Review of a progress note dated 04/29/2024 at 7:19pm by Registered Nurse #6 indicated that after providing wound care to Resident #1 the nurse called family to notify them of the change in skin condition, the Nurse documented in their note that the family replied to the nurse that the Hospice nurse had notified them of the change in skin condition already. Review of a note dated 04/24/2024 written by a Registered Nurse #7 documented Resident #1 is on Hospice. Review of the discharge paperwork from the hospital dated 04/4/2024 documented Resident #1's disposition as: Patient is medically optimized for discharge back to subacute rehab, Hospice case management working on placement, anticipate discharge tomorrow. Review of all the care plans for Resident #1, revealed that there are no care plans for or related to Hospice. In an interview on 08/22/2025 at 2:35pm with Registered Nurse #1 when asking about the process for Hospice and how the exchange of information occurs. Registered Nurse #1 stated that there is a Hospice doctor, nurse, and aide, but they only see them once a week for a short period of time. Registered Nurse #1 stated the Hospice provider writes a note in their own book, and they must let the nurse manager on the unit know who they saw and if there is anything new. Registered Nurse #1 stated they did not think there is a Hospice note in the system. Registered Nurse #1 stated they described the system of communication as such: Hospice sees the resident and tells the nurse floor manager for that day, who then writes a note and contacts the facility doctor if there are any new orders or changes to orders. In an interview on 09/02/2025 at 10:11am with the Nursing Home Coordinator for the Hospice provider, they confirmed that Resident #1 was receiving Hospice services at the facility and that the beginning date was 04/05/2024. The Nursing Home Coordinator stated that while Resident #1 was at the facility, they had 3 nursing visits from the assigned Hospice Case Manager on 04/09/2024, 04/18/2024, and 04/29/2024. The Nursing Home Coordinator stated Resident #1 had Certified Nurse Aide visits, with different Aides, on 04/11/2024, 04/15/2024, 04/20/2024, 04/25/2024, 04/27/2024, and 04/29/2024. The Nursing Home Coordinator stated Resident #1 also had a Hospice social worker that visited on 04/08/2024 and 04/25/2024, and they had a Nurse Practitioner face-to-face visit to recertify on 04/25/2024. In an interview on 09/08/2025 at 3:43pm with the Director of Social Work, they stated that they update the care plan and share with team that the resident is on Hospice. The Director of Social Work stated they are available to talk to the Hospice nurse and to maintain contact with family to provide support. The Director of Social Work stated they cannot have this type of a conversation or do anything with a care plan if they are not aware a resident is on Hospice. In an interview on 09/09/2025 at 10:28am with the Nurse Liaison they went through all their information from 2024 and stated that the admissions alert email that they would have sent doesn't say anything about Hospice, usually that is where it would be- somewhere the ball got dropped- usually there is an email with the information. The Nurse Liaison stated they did not see where this information was relayed to the staff. the Nurse Liaison stated they cannot find anything that says this, they did not put it in the email to the admissions person at the facility. The Nurse Liaison stated that they obviously dropped the ball. 10NYCRR 415.11(c)(1)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on record review, and interviews conducted during the abbreviated Survey (NY00341591), the facility did not provide services in accordance with professional standards of care. Specifically, for one (Resident #1) of three residents reviewed for Hospice, Resident #1 was receiving Hospice care from an outside agency; however, the resident record contained no documentation, orders, progress notes, medical provider notes, or care plans addressing the Hospice care. The facility policy titled Hospice Services last revised 07/2025 documented that nursing coordinates the plan of care and ongoing collaboration and communication closely with Hospice, the resident and family, and other disciplines. The facility policy titled Interdisciplinary Care Planning last revised 04/15/2024 documented that a comprehensive resident-centered Care Plan is developed by the Interdisciplinary Team upon admission and reviewed/updated on a regular basis throughout the resident's length of stay. Resident #1 was admitted to the facility with diagnoses that included unspecified fracture of right femur, hypotension, encounter for palliative care. Review of the electronic medical record for Resident #1 shows there were no orders for Hospice, there were no progress notes from any medical provider indicating that they were collaborating with the Hospice facility, and there were no care plans that indicate that the facility had a comprehensive resident-centered care plan developed. Review of a progress note dated 04/29/2024 at 7:19pm by a Registered Nurse #6 indicated that after providing wound care to Resident #1 the nurse called family to notify them of the change in skin condition, the Nurse documented in their note that the family replied to the nurse that the Hospice nurse had notified them of the change in skin condition already. In an interview on 08/22/2025 at 2:35pm with Registered Nurse #1 when asked about how the Hospice care is documented and how Hospice care is provided, they stated there is a Hospice doctor, nurse, and aide. The Registered Nurse #1 stated the Hospice staff only see the resident once a week for a short period of time and the Hospice provider writes a note in their own book, and they must let the nurse manager on the unit know who they saw and if there is anything new. Registered Nurse #1 stated they do not think there is a Hospice note in the system. They stated they think the way it goes is Hospice sees the resident and tells the unit manager which residents were seen and then writes a note and contacts the facility doctor if there are any new orders or changes to orders. In an interview on 09/02/2025 at 10:11am with the Nursing Home Coordinator for the Hospice provider, they confirmed that Resident #1 was receiving services at the facility and that the beginning date was 04/05/2024. The Nursing Home Coordinator stated that when Resident #1 was at this facility, they had 3 nursing visits from the assigned Hospice Case Manager on 04/09/2024, 04/18/2024, and 04/29/2024. The Nursing Home Coordinator stated Resident #1 had Certified Nurse Aide visits, with different Aides on 04/11/2024, 04/15/2024, 04/20/2024, 04/25/2024, 04/27/20/24, and 04/29/2024. The Nursing Home Coordinator stated Resident #1 also had a Hospice social worker that visited on 04/08/2024 and 04/25/2024, and they had a Nurse Practitioner face-to-face visit to recertify on 04/25/2024. The Nursing Home Coordinator for Hospice stated that they reviewed the process and that they have worked with this facility often. The Nursing Home Coordinator stated when a staff member goes into the facility, they must check in with the manager on the unit and let them know who they intend to visit with and check if there are any changes, and after the visit they return to the manager and let them know if there are any recommendations. They explained that every unit should have a binder and that is where the staff write any notes about the resident they are visiting. In an interview on 09/05/2025 at 10:10am with the Medical Director, they stated they always write an order if the resident is on Hospice. The Medical Director stated that they reviewed the process for residents on Hospice at the facility. The Medical Director stated that there are residents that get Hospice, and it is all from the same Hospice facility. The Medical Director stated that they haven't seen any notes written about Hospice for this resident, The Medical Director stated they were not aware of any binder on the units regarding Hospice. The Medical Director reiterated that they must have an order for Hospice, and that this is the first time they were hearing about this issue. The Medical Director added that the problem is no one noticed. In an interview on 9/9/25 at 10:28am with the Nurse Liaison they went through all their information from 2024 and stated that the admissions alert email doesn't say anything about Hospice, usually that is where it would be - somewhere the ball got dropped - usually there is an email with the information. The Nurse Liaison stated they did not see where this information was relayed to the staff. The Nurse Liaison stated they cannot find anything that says this, they did not put it in the email to the admissions person at the facility. 10 NYCRR 415.11(c)(3)(ii)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility did not provide evidence that care plan interventions were consistently carried out for the resident reviewed for pressure injuries. Specifically, Resident #1 who was admitted with a deep tissue injury, had an intervention to turn and position every two hours which wasn't consistently documented indicating this intervention was not properly performed. Review of the policy titled Documentation of Pressure Ulcer and Chronic Wounds last revised 6/2023 documented that Pressure ulcers and chronic wounds are monitored closely to monitor effectiveness of treatment and change in risk factors. Review of the policy titled Activities of Daily living last reviewed 9/2025 documents that each resident will receive, and the facility will provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. This policy further documented that Certified Nurse Assistants will follow the resident Kardex/ Care Plan interventions (i.e. transfer status, turning and positioning, assistive devices, ADLs, etc.).Resident #1 was admitted to the facility with diagnoses that included unspecified fracture of right femur, hypotension, encounter for palliative care.In review of all notes provided by facility from date range of when Resident #1 was in the facility, from 04/05/2024 until 05/03/2024, there were only 14 notes that indicate Resident #1 may have been moved from one position to another and possibly off their back. Of those 14 notes only five (5) indicate that Resident #1 was actually turned and positioned. Most notes just indicate that Resident #1 may have been moved, they do not specifically document that they had been turned and positioned either when the note was written or every two hours as per the care plan. Review of note dated 05/02/2024 at 10:46pm by Registered Nurse #7 documented Resident #1 resting comfortable in bed with eyes closed. Took all post meridiem (PM / evening) and [NAME] somni (HS / at bedtime or hour of sleep) medications without adverse reaction. Turned and positioned every two hours, heels off loaded. Skin beneath immobilizers is dry and intact, positive pedal pulses. No complaints of pain or discomfort. Review of note dated 05/02/2024 at 1:59pm by Registered Nurse #7 as prior message documented continue to offload heels and turn and position resident everyone (1) to two (2) hours or as per facility protocol.Review of note dated 04/30/2024 at 3:21pm by Social Worker #8, documented that Resident #1 was having a room change, so while it does not explicitly state that the resident was turned or positioned it is probable that they were moved around and possibly off their back.Review of progress note dated 04/30/2024 at 10:52am by Nurse Practitioner #1 documented that Resident #1 was being examined for skin impairment involving multiple areas. It further documents that to improve the patient's comfort and healing an air mattress will be added to reduce pressure on the affected areas with turning and positioning as they tolerate.Review of progress note dated 04/29/2024 at 6:55pm by Registered Nurse #6 documented that the Assistant Director of Nursing is in the process of getting an air mattress from the maintenance department. It further documented that Resident #1 was repositioned on their right side with both heels off loaded with pillows. Review of progress note dated 04/28/2024 at 12:07pm by Registered Nurse #7 documented that Resident #1 turned and positioned every two hours, and treatment to buttocks completed.Review of progress note dated 04/27/2024 at 1:53pm by Registered Nurse #7 documented that Resident #1 turned and positioned every two hours, and treatment to buttocks completed. Review of progress note dated 04/25/2024 at 12:06pm by Licensed Practical Nurse #9 documented that the patient (Resident #1) was examined on wound rounds and that they remain to be turned and positioned every 2 hours and as necessary.Review of progress note dated 04/22/2024 at 2:54pm by Registered Nurse #7 documented that Resident #1 went out to an orthopedic appointment.Review of progress note dated 04/06/2024 at 2:06pm by Licensed Practical Nurse #10 documented that ADL care was provided. Review of care plans found that Resident #1 had a care plan initiated 04/06/2024 with a focus of Bed Mobility documented that resident had a self-performance deficit related to fracture of bilateral femur, limited mobility, limited range of motion. The intervention date initiated 04/06/2024 will continue to be positioned safely through next review intervention dependent x2 rolling side to side.Review of care plans found that Resident #1 had a care plan initiated 04/05/2024 with a focus of Skin Integrity at risk: at risk for impaired skin integrity related to fracture of bilateral femur, limited mobility, limited range of motion, surgery left intramedullary nailing, incontinence, deep tissue injury sacrum, and redness to inner heel. The goal was that Resident #1 would be free from further skin breakdown through next review. One of the interventions dated 04/05/2024 documented Turn and Position every 2 hours and as needed. In an interview on</p>		

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<p>F 0711</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews during an abbreviated survey (NY00341591), the facility did not have a resident's total program of care created, specifically orders for Hospice were never entered by the medical provider for one (Resident #1) of three residents reviewed for Hospice. Specifically, Resident #1 was admitted on [DATE] and was on Hospice care from their prior facility and the Physician has no progress note addressing this and there are no orders to continue Hospice care for Resident #1 who was being seen regularly by the outside Hospice provider. The facility policy titled Hospice Services with a revision date of 07/2025 document that there is a collaborative effort between Hospice and the facility for residents with life-limiting illnesses. The Facility will maintain a written agreement with Hospice. Resident #1 was admitted on [DATE] and in review of the entire chart, there are no orders, no physician notes documenting physician was aware resident was on Hospice. Review of all notes and orders provided by facility from date range of when Resident #1 was in the facility, from 04/05/2024 until 05/03/2024, there were no orders for Hospice care, and there were no notes written to indicate that the Medical Director was aware that Resident #1 was on Hospice care. In an interview on 09/05/2025 at 10:10am with the Medical Director, they stated they always write an order if the resident is on Hospice. The Medical Director stated that they reviewed the process for residents on Hospice at the facility. The Medical Director stated that there are residents that get Hospice, and it is all from the same Hospice provider. The Medical Director stated that they haven't seen any notes written about Hospice for Resident #1. The Medical Director stated they were not aware of any binder on the units regarding Hospice. The Medical Director reiterated that they must have an order for Hospice, and that this is the first time they were hearing about this issue. The Medical Director stated that this was my mistake and that they did not know how this happened without an order. The Medical Director added that the problem is no one noticed. 10 NYCRR 415.15 (b)(2)(iii)</p>		