| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 335789 | A. Building<br>B. Wing | 02/12/2026 |

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

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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 during a recertification survey from 2/05/2026 to 2/12/2026, the facility did not ensure that food was stored in accordance with professional standards for food service safety. Specifically, twelve (12) food items were not properly identified and dated in the kitchen refrigerators, freezers, and food storage areas.The findings include:The policy titled Food Receiving and Storage last revised December 2012, documented all opened items would be labeled, dated and discarded after three (3) days once opened. On 2/05/2025 at 9:31 AM, the initial inspection of the kitchen was conducted with the Food Service Manager, and the following were observed:One (1) gallon container of milk with no opened date and a one (1) quart container of half & half with no opened date in the night prep refrigerator.One (1) bag of chicken tenders with no identification label and one (1) bag of meatless chicken tenders with no identification label in the walk-in-refrigerator.One (1) bag of frozen pizza with no identification label and one (1) container of hot dogs with no identification label in the freezer. One (1) tray of Cheerio cereal in bowels with no identification label, one (1) bag of breadcrumbs with no opened date and no identification label, and one (1) bag of dry elbow macaroni with no opened date in the dry storage area.One (1) container of rice with no identification label, and one (1) container of flour with no identification label in the bulk storage area.One (1) quart container of almond milk with no opened date in the milk storage refrigerator. During an interview on 2/12/2025 at 9:27 AM, the Food Service Manager stated it was not acceptable for food not to be labeled with the date opened and identification on it. They stated they expected staff to follow the facility policy on food storage with proper labeling and dates. 10NYCRR 415.14(h) |

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 0553<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Allow resident to participate in the development and implementation of his or her person-centered plan of care.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure that staff facilitated the inclusion of the resident or resident representative in all aspects of person-centered care planning that supports the resident's goals, choices, and preferences including potential for return to a community setting for one (1) of two (2) residents reviewed for Discharge. Specifically, Resident #22 was admitted on [DATE] for short term rehabilitation and there was no documented evidence that Resident #22 and/or their representative were invited to participate in the Comprehensive Care Plan meeting. Additionally, there was no documented evidence that evaluation of Resident #22's discharge needs and/or options was ongoing prior to notification of their Medicare coverage ending on 01/23/2026. The findings include:Resident #22 was admitted to the facility with diagnoses that included repeated falls, chronic kidney disease, and benign prostatic hyperplasia (noncancerous enlargement of the prostate).The 01/01/2026 Social Work progress note documented Resident #22 was alert and oriented times four, and able to make their needs known. The resident's overall goal was to discharge to the community. The 01/02/2026 five-day Minimum Data Set assessment documented Resident #22 had intact cognition, participated in assessment and goal setting, the goal was to discharge to the community, and active discharge planning was occurring. The 01/09/2026 care plan titled Discharge Planning documented Resident #22 would adjust to the subacute rehabilitation stay as evidenced by positive verbalizations/observations through the next review. Maintain customary routine/treatment and evaluate preferences and needs for possible transition to community.The Notice of Medicare Non-Coverage form was signed and dated by Resident #22 on 01/21/2026 and documented Medicare coverage would end as of 01/23/2026. The 02/05/2026 Medicare Non-Coverage appeal determination letter documented the appeal was denied. There was no documented evidence of an interdisciplinary care plan meeting to address discharge planning for Resident #22. During an interview on 02/05/2026 at 10:20AM, Resident #22 stated they did not recall if they had a care plan meeting yet. They stated they planned to go home.During an interview on 02/11/2026 at 2:12 PM, the Director of Social Work stated discharge plans started at the time of admission. They stated they were aware that Resident #22 would like to return home. They stated they usually scheduled care plan meetings within a couple of weeks of admission, but Resident #22 had not had a meeting since they arrived. They stated because the resident had COVID, the discharge process was held up. They stated they would meet with therapy to check on Resident #22's progress and then would schedule a meeting with the resident and their family.The 02/12/2026 Social Work progress note documented an interdisciplinary care plan meeting was conducted. Resident #22 is unsure if they want to remain in the facility as a long-term resident, pursue assisted living facilities, or return to their home in the community where they resided alone. Resident #22 does own a home in the community, however there is a mold issue in the basement and friends have informed the resident that it is unsafe. Resident #22 plans on speaking to a lawyer to assist with the financial piece. Resident #22 is also aware that they are currently paying privately here at the facility. Resident #22 will speak with the business office manager here at facility to discuss payment options. Resident #22 plans on speaking with family to determine what would be the best living situation for them. Resident's general medical condition has been stable since getting over Covid. However, they continue to require assistance with walking and activities of daily living. Care plan goals reviewed and remained ongoing at this time. During a follow up interview on 02/12/2026 at 2:01 PM, the Director of Social Work stated Resident #22 was admitted for short term rehabilitation and it was determined on 01/01/2026 that their plan was to discharge home. They stated there had been no further discharge planning until today. They stated Resident #22 did receive the Notification of Non-Medicare Coverage on 1/21/2026, which they appealed and lost, but there was no meeting at that time to discuss options or discharge planning. They stated the first day of private<br>(continued on next page) |

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| F 0553<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | pay was 02/06/2026 which the business office discussed with the resident. They stated they did not have a follow-up discussion with Resident #22. They stated it was determined in the meeting today that Resident #22 was now uncertain whether they wanted to stay long term, go to assistive living, or receive assistance at home because of mold in their house and it may not be safe for them to return to their house. The Director of Social Work stated they should have planned a meeting sooner to plan the discharge for Resident #22 and could not say why they missed it.10 NYCRR 415.11(c)(2)(i-iii) |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.<br><br>Based on observation, interview, and record review during the recertification survey and abbreviated survey (NY002683111) the facility did not ensure that grievances were resolved in a timely manner for (2) two of (4) four residents (Residents #24, and #162) reviewed for Personal Property. Specifically, 1) Resident #24 was missing a red flip phone as of 11/24/2025 and (2) Resident #162 was missing an iPhone case, and gold colored chain and cross as of 11/21/2025. Both residents were not provided with reimbursement as of 2/12/26. The findings include:The policy titled Management of Patient /Resident and Family Complaints Concerns/Grievances effective 01/01/2000 documented the facility would make prompt efforts to resolve complaints/concerns/grievances. The resident and/or designated representative will be instructed of both the facility and the Department of Health complaint procedures verbally and in writing. 1) Resident #24 was admitted to facility with diagnoses including Heart Failure and Depression.The 11/21/2025 quarterly Minimum Data Set (assessment tool) documented Resident #24 was cognitively intact. The 11/24/2025 Grievance Form documented a red flip phone was missing x 4 days. The family replaced the phone, and the facility would reimburse the cost of the phone, awaiting receipt from the family. The Grievance Form was signed as resolved on 12/01/2025.There was no documented evidence of the cost of reimbursement or that a check was provided to the family on 12/01/2025.During interview on 2/06/2026 at 11:58 AM Resident #24 stated their red flip phone went missing in November 2025. They further stated the nursing staff looked for it but never found it. They stated they were not provided with reimbursement of the phone.The 02/11/2026 note written by the Director of Social Work documented writer conducted a follow up call with the resident's family/daughter in law yesterday regarding a satisfactory resolution. Family informed the writer that they would return their call within a week. Writer will continue to follow up. 2) Resident #162 was admitted to facility diagnoses including Spinal Stenosis, End Stage Renal Disease and Diabetes.The 11/21/2025 Grievance Form documented Resident #162 reported a gold-colored chain with medal cross and an iPhone case was missing. Housekeeping and dietary staff were made aware, and room search was completed. The facility offered reimbursement and was awaiting an estimate from the family. The grievance form was signed as resolved on 12/01/2025.The 11/28/2025 quarterly Minimum Data Set assessment documented Resident #162 had moderately impaired cognition.There was no documented evidence of the cost of reimbursement or that a check was provided to the family on 12/01/2025.During an interview on 02/10/2026 at 1:36 PM and 1:46 PM, the Director of Social Work stated they made follow-up calls yesterday to the designated representatives for Resident #24 and Resident #162. They stated the designated representative for Resident #24 was supposed to come in on 02/09/2026 to provide information on the cost of the replacement phone and never showed up. The Director of Social Work stated the designated representative for Resident #162 was called and they were still waiting to receive the information on the value of the missing iPhone case and gold colored chain and cross. The Director of Social Work stated they liked to resolve grievances within 24 hours. They stated they had no explanation as to why reimbursement was not provided to the residents and/or designated representatives when the items were reported missing in November 2025. During an interview on 02/10/2026 3:04 PM, Administrator #2 stated Resident #24 had a red flip phone and when they asked Resident #24 about when it went missing, they stated the resident could not recall when it was lost. Administrator #2 stated the flip phone was on a plan and that the designated representative replaced it. They stated they felt the grievance was resolved when they offered reimbursement to the designated representatives for Resident #24 and Resident #162. They stated they never received information from the designated representatives of Resident #24 and Resident #162 and were waiting for them to call with the information. Administrator #2 stated they were unsure as to why there was no documentation of the follow up calls made to the resident representatives or attempts to finalize the reimbursement when the missing items were reported in<br>(continued on next page) |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | November 2025.The 02/11/2026 note written by the Director of Social Work documented the writer conducted a follow up call yesterday with Resident #162's daughter to follow up with a satisfactory resolution. The family/daughter will call the writer back. The writer will continue to follow up.During an interview on 2/11/2026 at 3:08 PM, Administrator #1 stated although they were not aware of the specifics, they were aware of the facility reported incident for both Resident #24 and Resident #162. They stated that was the reason for the follow-up calls on 02/09/2026. Administrator #1 stated when the designated representatives of Resident #24 and Resident #162 were called, they were offered reimbursement. They stated the facility was still waiting for information on the value of the items. They stated the Director of Social Work called them again on 02/11/2026 to check on the status and were still waiting for a response from the designated representatives of Resident #24 and Resident #162. Administrator #1 stated they felt the resolution was completed by offering reimbursement and had no explanation as to why the reimbursement was still not provided to the family since the missing items were reported in November 2025.415.3(c)(1)(ii) |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure that a copy of the notice of transfer or discharge was sent to the State Long Term Care Ombudsman for two (2) of three (3) residents (Resident #14, Resident #158) reviewed for Hospitalization. Specifically, 1) there was no documented evidence that a notice of transfer was sent to the New York State Ombudsman when Resident #14 was transferred to the hospital on [DATE], and 2) there was no documented evidence that a notice of transfer was sent to the New York State Ombudsman when Resident #158 was transferred to the hospital on [DATE], The findings include:<br><br>The policy titled Discharge Notice last revised 06/2025, documented when a resident is temporarily transferred on an emergency basis to an acute care facility, notice of the transfer may be provided to the resident and resident representative as soon as practicable, according to 42 CFR 483.15(c)(4)(ii)(D). Copies of notices for emergency transfers must also still be sent to the ombudsman, but they may be sent when practicable, such as in a list of residents on a monthly basis. A copy is kept in the resident record.<br><br>1) Resident #14's diagnoses included fracture of the right femur.<br><br>The 11/16/2025 nursing progress note documented Resident #14 was admitted to the hospital with essential hypertension, dementia and a right hip fracture.<br><br>The 11/16/2025 transfer/discharge notice had a documented resident representative signature, dated 11/17/2025.<br><br>The 11/18/2025 bed hold policy form had a documented resident representative signature.<br><br>There was no documented evidence that the New York State Ombudsman office was notified of Resident #14's 11/16/2025 transfer to the hospital.<br><br>Resident #14 returned to the facility on [DATE].<br><br>2) Resident #153's diagnoses included unspecified dementia and malignant neoplasm of the left breast<br><br>The 11/13/2025 nursing progress note documented Resident #153 was sent to the hospital due to uncontrolled pain.<br><br>The 11/15/2025 transfer/discharge notice documented the resident representative was verbally notified on 11/13/2025.<br><br>There was no documented evidence that the New York State Ombudsman office was notified of Resident #153's 11/13/2025 transfer to the hospital.<br><br>The 11/14/25 nursing progress note documented the emergency room nurse reported that the designated representative was at the bedside requesting the patient be transferred to hospice for end-of-life care.<br>(continued on next page) |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 02/11/2026 at 9:38 AM, the Director of Social Work stated they kept a binder with a monthly transfer/discharge list, completed transfer/discharge forms and the bed hold forms. They stated the binder was available for the Ombudsman to review at their request. The Director of Social Work stated they had not sent/emailed copies of completed transfer and/or discharge notification forms or a monthly resident transfer/discharge list to the Ombudsman's office during the last six (6) months.<br><br>During an interview on 02/12/2026 at 12:37 PM, the Ombudsman stated they had not received a copy of Resident #14 and Resident #153's transfer and/or discharge notification form. They stated they had not received a monthly list of residents that had been discharged /transferred from the facility since April 2025.<br><br>10 NYCRR 483.15 © (3) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>Based on record review and interview the facility did not ensure accuracy of resident assessments for (1) one of (1) one resident (Resident #110) reviewed for Accidents, and (1) one of (1) one resident (Resident # 2) reviewed for Edema. Specifically, Resident #110 had documented falls on 08/09/2025 and 10/21/2025 that were not identified on their Minimum Dat Set assessments, and Resident #2 had a documented 12/04/2025 facility acquired stage three pressure ulcer that was coded on the Minimum Data Set assessment as having been present on admission to the facility. The findings include:<br><br>The policy titled Minimum Data Set, last revised 02/2025, documented that the Minimum Data Set is expected to accurately reflect the resident status.<br><br>1)Resident #110 had diagnoses including orthopedic conditions, cancer, and osteoarthritis of the knee.<br><br>The 8/09/2025 Accident /Incident Report documented Resident #110 was observed on the floor in front of their wheelchair.<br><br>The 9/26/2025 quarterly Minimum Data Set assessment documented no falls anytime in the last month prior to admission, no falls in the last 2 to 6 months<br><br>The 10/21/2025 Accident /Incident Report documented Resident #110 was observed on the floor of their room.<br><br>The 12/12/2025 annual Minimum Data Set Assessment documented no falls since admission/entry or reentry or the prior assessment.<br><br>On 02/11/2026 at 10:15 AM during an interview and record review, the Minimum Data Set Licensed Practical Nurse stated Resident #110's fall on 08/09/2025 was not documented on the 09/26/2025 quarterly Minimum Data Set assessment and Resident #110's fall on 10/21/2025 was not documented on the 12/12/2-25 annual Minimum Data Set assessment. They stated they completed the assessments and entered 'no falls' in error. They stated they overlooked the resident's falls. They stated they should have looked in the risk management tab in the electronic medical record to see a list of resident falls. They stated they were not aware of the correct process to note falls at the time of the assessments. They stated they recently learned the correct process for noting falls and would ask the regional Minimum Data Set nurse to submit corrections for both assessments.<br><br>2). Resident #2 had diagnoses that included cancer, hypertension, and anemia.<br><br>The 12/04/2025 wound care note for Resident #2 documented initial evaluation of stage three to the left ischium.<br><br>The 01/23/2026 quarterly Minimum Data Set documented Resident #2 had a stage three pressure ulcer that was present on admission.<br><br>During an interview on 02/11/2026 at 10:28 AM, the Minimum Data Set Licensed Practical Nurse stated they entered the wound information on the Minimum Data Set assessments. They stated they obtained their information from evaluations, progress notes, and wound care notes that were in the resident's electronic medical record. They stated Resident #2 did not have a pressure ulcer on<br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | admission. They stated they should have coded the pressure ulcer was not present on admission when they completed the 01/23/2026 Minimum Data Set assessment.<br><br>10NYCRR 415.11(b) |

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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>Based on observation, interview, and record review the facility did not ensure comprehensive care plans were reviewed and revised with each assessment and as needed to reflect residents changing needs. This was evident for two (2) (Resident #4 and Resident #11) of five (5) residents reviewed for Unnecessary Medication. Specifically, 1) the cardiac care plan for Resident #4 did not address the diagnosis of atrial fibrillation and use of anticoagulants, and 2) the psychosocial care plan for Resident #11 did not address the use of antipsychotic medication. The findings include:<br><br>The policy titled Interdisciplinary Care Planning last revised 09/25/2025 documented 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.<br><br>1) Resident #4 diagnoses included peripheral vascular disease, and atrial fibrillation.<br><br>The 01/16/2026 quarterly Minimum Data Set (a resident assessment tool) documented Resident #4 had moderate cognitive impairment and received anticoagulants.<br><br>The 02/03/2026 physician order documented Eliquis five (5) milligrams, give one (1) tablet by mouth twice a day.<br><br>There was no documented evidence in the cardiac care plan to address the diagnosis of atrial fibrillation and the use of anticoagulants.<br><br>During an interview on 02/11/2026 at 1:19 PM, the Director of Nursing stated they were unable to locate a care plan to address the use of anticoagulants for Resident #4. The Director of Nursing stated Resident #4 was taking an anticoagulant medication and should have interventions in place to monitor/report and signs/symptoms of bleeding/bruising. They stated the unit manager would have been responsible for updating Resident #4's care plan and the Assistant Director of Nursing, Director of Nursing and/or the Minimum Data Set Coordinator were responsible for overseeing that Unit Managers were updating care plans as needed.<br><br>During an interview on 02/11/2026 at 1:40 PM, Licensed Practical Nurse Unit Manager #1 stated they were aware Resident #4 was prescribed an anticoagulant. They stated a Registered Nurse could add an anticoagulant use care plan with interventions. They stated updates to care plan interventions was a unit manager role.<br><br>2) Resident 11's diagnoses included dementia in other diseases classified elsewhere mild with anxiety, and unspecified pain.<br><br>The 12/05/2025 quarterly Minimum Data Set documented Resident #11 had moderate cognitive impairment and received antipsychotic medication.<br><br>The 11/03/2025 physician order documented olanzapine oral tablet five (5) milligrams. Give five (5) milligrams by mouth at bedtime for major depressive disorder.<br><br>The 11/06/2025 care plan titled Psychosocial Well-Being documented administer non-psychotropic medication per physician order.<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 | During an interview on 02/10/2026 at 3:19 PM, Licensed Practical Nurse Unit Manager #2 stated Resident #11 received antipsychotic medication as per physician order. They stated they were unable to locate a care plan with interventions that addressed the use of antipsychotic medications. They stated they would discuss it with the Assistant Director of Nursing. They stated antipsychotic interventions could have been added under the psychosocial care plan. They stated the Social Work Department updated psychosocial care plans.<br><br>During an interview on 02/11/2026 at 9:27 AM, the Director of Social Work stated antipsychotic medication use was to be documented under psychosocial care plans. The Social Worker stated they were unable to locate the use of antipsychotics on the resident care plan. They stated they were responsible for updating Resident #11's care plan to address the use of antipsychotic medication. The Director of Social Work stated the care plan should include interventions such as use of antipsychotic medication, psychology and psychiatry consults as needed, monitor for changes and report for changes in behavior (acting out, increase in lethargy, and report changes.<br><br>10 NYCRR 415.11(c)(2)(i-iii) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 335789 | A. Building<br>B. Wing | 02/12/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Taconic Rehabilitation and Nursing at Hopewell | 3 Summit Court<br>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.

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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>Based on observation, record review, and interview during the recertification and abbreviated survey (623104/NY00345976), the facility did not ensure each resident received care, consistent with professional standards of practice, to treat and/or prevent pressure ulcers for two (2) of seven (7) (Residents #13 and Resident #143) reviewed for Pressure Ulcers. Specifically, 1) Resident #13 who was assessed as at risk for pressure ulcers was not provided heel offload/float as per the comprehensive care plan, 2) Resident #143 who was assessed as at risk for pressure ulcers was not provided heel offload/float as per physician order and comprehensive care plan and a pressure reducing device was not provided as per comprehensive care plan.The findings include:1)Resident #13's diagnoses included bipolar disorder, unspecified dementia without behavior disturbance, and dysphagia.The current care plan titled Skin Integrity documented Resident #13 was at risk for impaired skin integrity related to impaired mobility. Float heels when in bed. The 12/26/2025 quarterly Minimum Data Set (a resident assessment tool) documented Resident #13 had severe cognitive impairment, was dependent on staff with bed mobility, was at risk for pressure ulcers and had one stage IV pressure ulcer present on admission/reentry.The 02/12/2026 certified nurse aide Kardex (resident task sheet) documented skin integrity: float heels when in bed, reposition every two (2) to four (4) hours and as needed. Pressure relief mattress.During observation on 02/05/2026 at 9:47 AM and 02/06/2026 at 9:19 AM, Resident #13's bilateral heels were resting on the mattress. The heels were not offloaded/floated.During observation and interview on 02/09/2026 at 12:49 PM, Certified Nurse Aide #8 stated Resident #13's bilateral heels rested on the mattress and were not offloaded/floated They stated the heels should be offloaded/floated. They stated Resident #13 was hand-fed lunch a short time earlier and their heels should have been checked to ensure they were offloaded/floated.During interview and observation on 02/09/2026 at 12:56 PM, Licensed Practical Nurse #7 stated Resident #13's bilateral heels were not offloaded/floated. They stated Resident #13 had a care plan intervention for their heels to be offloaded when in bed. They stated the resident's heels should be offloaded because they were bedbound. They stated all nursing staff including certified nurse aides were responsible for ensuring the resident's heels were offloaded/floated. They stated nurses were responsible for ensuring that certified nurse aide tasks were completed. During interviews on 02/10/2026 at 10:18 AM and 02/12/2026 at 4:26 PM, Licensed Practical Nurse Unit Manager #2 stated Resident #13 had a care plan intervention for heels to be offloaded/floated when they were in bed. They stated staff should have used pillows or a wedge type device to offload/float the heels. They stated nurses were responsible for ensuring certified nurse aides offloaded the resident heels. 2) Resident #143 diagnoses included unspecified epilepsy non-intractable with status epilepticus, history of transient ischemic attack and cerebral infarction without residual deficits and bipolar disorder. The 05/05/2025 physician order documented offload heels on pillow in bed as tolerated every shift for skin integrity. The 05/08/2025 care plan titled Skin Integrity documented Resident #143 was at risk for impaired skin integrity related to diabetes mellitus type one (1) and impaired mobility. Offload heels while in bed on a pillow as tolerated, turn and reposition every two (2) to four (4) hours while in bed as needed, float heels while in bed, and pressure reduction device for out of bed. The 06/06/2025 occupational therapy progress note documented Resident #143 was provided with a reclining high back wheelchair with elevating leg rests. Resident currently with aqua cell cushion in the wheelchair. The 10/22/2025 care plan titled Transfer documented Resident #143 had a self-performance deficit related to muscle weakness. Pressure reduction device for out of bed. The 01/16/2026 quarterly Minimum Data Set documented Resident #143 had moderate cognitive impairment, required substantial/maximal assistance for bed mobility, was at risk for pressure ulcers and did not have a pressure ulcer. The current Kardex documented under the skin integrity section, off load heels on a pillow while in bed.During observation on 02/05/2026 at 11:46 AM, 02/06/2026 at 11:22 AM and 02/09/2026 at 9:46 AM, Resident #143 was in bed with their bilateral heels on the<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | mattress. The heels were not offloaded. During observation on 02/09/2026 at 11:46 AM and 02/10/2026 at 11:41 AM, Resident #143 was sitting in their wheelchair, without the use of a pressure relieving device/cushion.During interview and observation on 02/10/2026 at 11:42 AM, Certified Nurse Aide #9 stated Resident #143's wheelchair did not have a pressure relieving device/cushion in place. They stated the last time they observed Resident #143's cushion was in late December 2025 when Resident #143 was using a Geri chair. They stated Resident #143 was transitioned to a high back wheelchair at the beginning of 2026 and they did not observe the cushion since that time. They stated they did not report that Resident #143 did not have a cushion to nurses and rehabilitation staff. They stated they should have reported the missing cushion. During observation and interview on 02/10/2026 at 1:53 PM, Resident #143 was in bed resting on their back with their bilateral heels on the mattress. The heels were not offloaded/floated. Certified Nurse Aide #9 stated they were not aware that Resident #143 had a physician order and care plan intervention to offload/float the heels while in bed. They stated the task was not documented on the Kardex (certified nurse aide task document).During an interview on 02/11/2026 at 11:33 AM, Licensed Practical Nurse Unit Manager #1 stated Resident #143 had a care plan intervention and physician order to offload/float bilateral heels when in bed and they were not aware why the task was not completed. Licensed Practical Nurse Unit Manager #1 stated certified nurse aides should complete the task as documented on the certified nurse aide Kardex. They stated Resident #143 should have a pressure reducing device/cushion on the wheelchair. They stated no staff reported the device/ cushion missing. They stated the last time they observed a cushion on Resident #143's wheelchair was over three weeks ago. During an interview on 02/11/2026 at 1:55 PM, the acting Director of Rehabilitation stated Resident #143 was at risk for pressure ulcers. They stated use of a pressure reduction device/cushion for the wheelchair was added to the care plan on10/22/2025. They stated the resident had the cushion at that time. They stated when unit staff noticed a missing cushion, they were supposed to report to rehabilitation staff during morning meeting, or they could complete a referral form at the nursing station. They stated they were not aware of unit staff requesting a replacement pressure reduction device/cushion. 10NYCRR 415.12(c)(1) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>Based on observation, interview, and record review the facility did not ensure care consistent with professional standards of practice, and the comprehensive person-centered care plan was provided for one (1) of three (3) residents (Resident #13) reviewed for Respiratory Care. Specifically, Resident #13 was administered oxygen at a liter flow greater than the current physician's order. Additionally, Certified Nurse Aide #8 did not adhere to enhanced barrier precautions when they had contact with and handled Resident #13's nasal cannula. The findings include:The policy titled Oxygen Therapy, last revised 09/2023, documented oxygen administered by licensed staff. Oxygen administration requires physician order.Resident #13's diagnoses included bipolar disorder, unspecified dementia without behavior disturbance, and dysphagia.The 06/07/2023 care plan titled Impaired Pulmonary Function documented administer oxygen per physician order.The 10/28/2025 physician order documented enhanced barrier precautions stage 4 wound sacrum. The 06/14/2025 physician order documented continuous oxygen via nasal cannula at two (2) liters per minute.The 12/26/2025 quarterly Minimum Data Set (a resident assessment tool) documented Resident #13 had severe cognitive impairment and received oxygen therapy. During observation on 02/05/2026 at 9:47 AM and 02/06/2026 at 9:26 AM Resident #13 received oxygen via nasal cannula at three (3) liters/minute. During observation and interview on 02/09/2026 at 12:43 PM and 12:49 PM Resident #13's nasal cannula was resting in Resident #13's hair/scalp on the top of their head. Certified Nurse Aide #8 removed the nasal cannula from Resident #13's hair/scalp without performing hand hygiene, donning gloves, or wearing a gown and inserted the cannula prongs into Resident #13's nostrils. Certified Nurse Aide #13 stated they should have applied appropriate personal protective equipment and performed hand hygiene before they handled and placed the nasal cannula in Resident #13's nostrils.During interview and observation on 02/09/2026 at 12:56 PM, Licensed Practical Nurse #7 stated they checked the oxygen flow rate for Resident #13 earlier in the shift between 8:00 AM and 9:00 AM. Licensed Practical Nurse #7 stated Resident #13's oxygen concentrator was running at three (3) liters/minute and stated they were not aware of the exact physician order for oxygen administration. After review, Licensed Practical Nurse #7 stated the physician order was for oxygen to be administered at two (2) liters/minute. They stated they should have double checked the order during medication administration and adjusted the oxygen flow rate to two (2) liters as per physician order. During interview on 02/10/2026 at 10:18 AM and 02/12/2026 at 4:26 PM, Licensed Practical Nurse Unit Manager #2 stated nursing staff were required to check oxygen flow rates during medication administration and during each shift to ensure the flow rate matched the physician order. Licensed Practical Nurse Unit Manager #2 further stated staff should mask, glove and gown when they provided cares for residents on enhanced barrier precautions. They stated nurses were responsible for supervision of certified nurse aides to ensure personal protective equipment was applied when necessary. 10NYCRR 415.12 (k)(6) |