STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335802	A. Building B. Wing	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glen Arden Inc	214 Harriman Drive Goshen, NY 10924

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on interview, observation and record review during the survey, the facility failed to ensure residents received care consistent with professional standards of practice to prevent pressure ulcers and to prevent worsening of pressure ulcers. This was evident for one (1) of three (3) residents (Resident #11) reviewed for pressure ulcers. Specifically, Resident #11 was assessed as at risk for pressure ulcers on admission and had no pressure ulcers. There was no documented evidence that offloading practices or turning and positioning were implemented to prevent pressure ulcers from developing. On 11/23/2025, a Stage 2 (damage to skin or underlying soft tissue) pressure ulcer to their left heel was identified. On 12/09/2025, Resident #11's left heel wound had progressed to a Stage 4 pressure ulcer (full thickness skin and tissue loss). Recommendations by the Wound Care Physician were made for turning and positioning, offloading and nutrition shakes on 11/25/2025, 12/02/2025 and 12/09/2025. There was no documented evidence that the Wound Care Physician's recommendations were implemented to prevent further deterioration of the wound. This resulted in actual harm for Resident #11 that was not Immediate Jeopardy.The findings include:The 03/28/2019 facility policy Pressure Ulcer Prevention and Management documented that all residents will be positioned off bony prominences, if a resident is unable to turn self independently, the staff will turn and position the resident as directed on the care plan and CNA resident summary and record turning and positioning, the physician writes orders for treatments as needed, and the dietitian makes recommendations for nutritional supplements/vitamin supplements and for caloric fluid intake. Resident #11's diagnoses included status post hip fracture with surgical intervention, osteoporosis, and non-Alzheimer's dementia. The 11/19/25 admission Minimum Data Set (a resident assessment) documented Resident #11 had impaired cognition and required substantial/maximal assistance with rolling left and right in bed. Resident #11 had no pressure ulcers present on admission. Resident #11 was at risk for developing pressure ulcers. The 11/12/2025 Comprehensive Nursing Assessment (admission assessment) documented Resident #11 was at risk for pressure ulcers. There were no documented pressure ulcers. There were 16 staples in the left hip.The 11/12/2025 Braden Scale (tool for predicting pressure ulcer risk) documented Resident #11 was at risk for pressure ulcers.The 11/12/2025 Risk for Skin Breakdown Care Plan documented interventions which included to keep heels elevated in bed, turn and position every two (2) hours in bed, administer protein supplements, vitamins, dietary supplements as ordered, dietary consult as needed, and Physical/Occupational Therapy consult for positioning devices as needed. The 11/12/2025 Primary Physician's Orders documented Body Audit Weekly with Nurse's Notes.The Resident Care Sheet (instructions for direct care staff) initiated 11/12/2025 with updates through 12/19/2025 provided no documented instructions for turning and positioning or offloading heels.The 11/22/2025 Registered Nurse #3's progress note documented 10 days since admission, poor appetite noted for three (3) meals, offered and enjoyed applesauce and cookies. Left hip with Steri Strips intact. Chronic pain addressed with pain medication as needed. Two (2) person assist to bed, call bell in easy reach with instructions to call for assistance. (Resident #11) will need reinforced teaching. The 11/23/2025 Registered Nurse #19's progress note at 11:02 PM documented Resident #11's left heel blister open with large amount of serous (thin, watery, clear to pale yellow fluid) drainage present. The wound was beefy in color (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0686 Level of Harm - Actual harm Residents Affected - Few	with a darkened center measuring 2.5 by 2.5 by 0 centimeters. The area of wound measured 5 by 4 by 0 centimeters. The physician was notified, treatment ordered and applied; the resident to be followed by the wound physician on Tuesday. The 11/23/2025 Primary Physician's Order documented Silver Sulfadiazine 1% topical cream (Silvadene): Cleanse left heel wound with wound cleanser, apply Silvadene, cover with dry protective dressing twice a day for four (4) days or until seen by Wound Care. The Risk for Skin Breakdown Care Plan, updated 11/23/2025, documented an intervention to off load heels from bed with pillows and or heel-up pads. The 11/25/2025 Wound Evaluation & Management Summary documented a Stage 2 pressure ulcer on the left heel measuring 4.5 by 3.2 by 0.1 centimeters, with good healing potential. The recommended treatment was calcium alginate (dressing for wound healing) once a day and as needed, gauze island with border once a day, cleanse with normal saline. General recommendation included offload wounds, float heels in bed, turn side to side in bed. Specific to visit recommendations included nutritional shakes three (3) times a day with meals, and offloading Darco shoes (used to support and offload pressure from the foot). The 11/25/2025 at 2:37 PM Registered Nurse Unit Manager #4 progress note documented Resident #11 was examined by the wound care physician for initial evaluation of an open blister to their left heel. Treatment recommendations were received and were approved by the primary physician. Staff to continue wound healing and pressure relieving interventions as tolerated; to utilize heel boots when in bed. Therapy to evaluate for Darco shoe to left foot. Wound Care Physician will follow-up again next week on rounds. The 11/26/2025 Primary Physician orders documented calcium alginate to wound bed covered with bordered foam dressing daily and as needed, and bilateral Darco shoes when out of bed to protect left heel and prevent new development of wounds on right foot. The orders did not include the nutritional shakes or any other recommendations from the Wound Care Physician. The November 2025 Treatment Administration Record had no documented evidence of care plan interventions including offloading Resident #11's heels in bed, turning and positioning every two (2) hours, or protein supplements were put in place. The weekly body audit was completed on 11/15/2025 and 11/22/2025 (day before pressure ulcer identified) and documented no skin issues. The November 2025 Certified Nurse Aide Documentation Worksheet (accountability for certified nurse aide tasks) had no documented evidence of turning and positioning or offloading heels.The 12/02/2025 Wound Evaluation & Management Summary documented a Stage 2 pressure ulcer on the left heel measuring 4.2 by 3.5 by 0.1 centimeters, and good healing potential. General recommendations included offload wounds, float heels in bed, turn side to side in bed and specific recommendations included nutritional shakes three (3) times a day with meals, offloading Darco shoes. The 12/09/2025 Wound Evaluation & Management Summary documented the resident was seen for a Stage 4 pressure ulcer of the left heel, full thickness. Wound size 3.2 by 3.5 by 0.1. centimeters. Surface area 11.2 centimeters, open ulceration area of 10.08 centimeters, light serous exudate, 90% thick adherent devitalized necrotic tissue(dead tissue), 10% intact normal skin color. General recommendations included offload wounds, float heels in bed, turn side to side in bed and specific recommendations included nutritional shakes three (3) times a day with meals, offloading Darco shoes. During an observation on 12/18/2025 at 10:02 AM, Resident #11 was sitting in their wheelchair wearing specialty shoes, and left leg swelling was observed.Review of Resident #11's electronic medical record on 12/18/2025, revealed no documented evidence of a nutritional assessment since the wound was identified, no supplements ordered, no documentation of turning and positioning or offloading. During an interview on 12/18/2025 at 2:35 PM, the Registered Dietitian stated they were unaware of the Resident #11's pressure ulcer. When notified of a pressure ulcer, they would add Vitamin C and a protein supplement if intake were poor. During an interview on 12/18/2025 at 4:29 PM, the Director of Nursing stated the Wound Care Physician did not come in this week on Tuesday (routine wound care day) and they would be doing wound rounds today (Thursday) via telehealth. They stated they would provide the tracking to the dietitian after rounds.The 12/19/2025 Registered Dietitian note documented recommendations for Pro-Stat (concentrated liquid (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	protein) 30 cc every day, Vitamin C 500 mg twice a day, Zinc sulfate 220 mg daily for 14 days to promote wound healing.The 12/19/2025 Primary Physician's Orders documented Pro-Stat 101, 15 gram-101 kcal/30 ml oral liquid, give 30 ml by oral route every day, Vitamin C 500 mg tablet by oral route twice a day, Zinc sulfate 220 mg tablet by oral route daily for 14 days. During an interview on 12/19/2025 at 12:26 PM, the Director of Nursing stated the Certified Nurse Aide Documentation Worksheet did not document turning and positioning or elevating Resident #11's heels, and they were not documented on the Resident Care Sheet instructions. They stated the Registered Nurse Unit Manager who wrote the care plan should have listed all the necessary interventions on the Resident Care Sheet instructions. The Director of Nursing stated they were responsible for assuring the Resident Care Sheet instructions included all necessary information for resident care. The Director of Nursing stated there were no Physician's Orders for offloading for Resident #11's heels in bed or for positioning in bed or for a protein supplement. The Director of Nursing stated a Clinical Nutrition Wound Note was not completed and there was no protein supplement ordered after the wound was identified, and there was no order for nutritional shakes despite the Wound Care Physician's recommendation on 11/25/2025. The Director of Nursing stated Registered Nurse Unit Manager #4 accompanied the Wound Care Physician and should have updated the care plan and should have reviewed any recommendations for treatments and supplements and assistive devices with the primary physician. The Director of Nursing stated that the primary physician was responsible for reviewing the wound consult sheets and recommendations and signing the consult sheets after reviewing them.During an interview on 12/22/2025 at 8:26 AM, Certified Nurse Aide #8 stated they were the daytime primary/regular aide who provided care to Resident #11 since Resident #11 was admitted to the facility. Certified Nurse Aide #8 stated they checked the Resident Care Sheet instructions on the computer for instructions on how to care for residents and how many staff were needed to provide cares. They stated they also asked the nurse or rehabilitation department for clarification and additional instructions. They stated that for Resident #11, they asked Physical Therapy and the nurse, and the nurse told them Resident #11 had staples to their left hip. They stated on the computer, there were no instructions about turning and positioning or heel booties until the surveyor asked them last week. They stated that nobody told them to elevate Resident #11's heels in bed, but they knew to do so although they were not sure when they started doing so. They stated during care, they did not notice a red area or a blister forming on Resident #11's left heel.During an interview on 12/22/2025 at 11:04 AM, Registered Nurse Unit Manager #4 stated that Registered Nurse Supervisor #10 completed Resident #11's admission assessment and the Resident Care Sheet on 11/12/25. Registered Nurse Unit Manager #4 stated that heel booties and turn and position every two (2) hours were not documented on the Resident Care Sheet on 11/14/2025. Registered Nurse Unit Manager #4 stated that based on Resident #11's left hip fracture and risk for pressure ulcers on assessment, the facility should have implemented heel booties or heels-up cushion and turn and position every two (2) hours. Registered Nurse Unit Manager #4 stated that between themself and the Director of Nursing, one or the other was responsible to review new admissions to assure all necessary interventions were in place and documented. Registered Nurse Unit Manager #4 stated that heel booties were not ordered until 12/18/2025. Registered Nurse Unit Manager #4 stated that elevating Resident #11's heels on pillows was not documented in a physician's order or in the Treatment Administration Record or on the Resident Care Sheet. Registered Nurse Unit Manager #4 stated they accompanied the Wound Care Physician on 11/25/2025 and updated the care plan but did not enter the recommended interventions on the physician's orders or on the Resident Care Sheet although they were responsible to do so. Registered Nurse Unit Manager #4 stated they reviewed the Wound Evaluation & Management Summary however they were not aware that nutritional shakes three (3) times a day were recommended. They stated if they had been aware, they would have called the physician to ask for an order for nutritional shakes as recommended. Registered Nurse Unit Manager #4 stated they gave the Registered Dietician a new wound sheet the following Wednesday (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	(12/03/2025) and explained which residents had new wounds, location of the wounds, and stage of the wound, and stated the Registered Dietician is expected to review the Wound Evaluation & Management Summaries, discuss preferences with resident and/or resident family, and document their recommendations on paper or by email to Registered Nurse Unit Manager #4. Registered Nurse Unit Manager #4 stated if they had received any dietary recommendations, they would have called the physician for an order.During an interview on 12/22/2025 at 12:07 PM, the Registered Dietician stated they were on vacation for the 11/26/2025 wound rounds and when they came back from vacation on 12/03/2025, they did not receive a new wound sheet from Registered Nurse Unit Manager #4. The Registered Dietician stated they were not aware of Resident #11's left heel wound until 12/18/2025. They stated that if they are on vacation, the nurse should call the physician if any supplements are recommended /needed. During an interview on 12/22/2025 at 1:22 PM, the Wound Care Physician stated their expectation was that the facility would either follow their recommendations or call them to discuss other options. They stated that since the wound had deteriorated, heel offloading and nutritional shakes had likely not been consistently implemented. They stated if the facility had followed the recommendations that they had documented on their wound care notes, the wound would likely have not deteriorated. They stated there was no medical cause for the wound to deteriorate other than pressure and nutritional needs. They stated that a wound would only deteriorate if the resident had an allergy or an infection or if they have a disease process causing the wound or related to the wound, or if offloading is not being performed and nutrition is not being supplemented. They stated they had not performed wound rounds with the Registered Dietician at the facility. They stated that pressure being applied to the site was most likely the cause of the wound deterioration. They stated deterioration of the wound was preventable if the facility staff and resident had worked together to implement all necessary interventions for healing which included nutritional supplements and offloading. They stated it was likely that the wound deteriorated because implementation of interventions did not occur. During an interview on 12/22/2025 at 3:29 PM, Registered Nurse Supervisor #10 stated they completed the admission assessment, Braden Scale and the Resident Care Sheet for Resident #11 on admission. They stated that since Resident #11 was admitted with a left hip fracture and scored at risk for pressure ulcers, they should have entered offloading/heel booties and turning and positioning on the Resident Care Sheet instructions so that the Certified Nurse Aides would have been aware of the interventions. 10 NYCRR 415.12(c)(2)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview the facility did not ensure food was stored and prepared in accordance with professional standards for food service safety. Specifically, 1) unsealed, unlabeled, and undated foods were stored in the refrigerators and freezer, 2) expired foods were stored in the dry pantry, walk in cooler, and reach- in refrigerator, and 3) staff were observed not wearing hair and beard restraints while in the kitchen. The findings include: The policy last revised 5/2018 titled Labeling and Dating documented all foods must be labeled and dated to ensure foods are being used in a proper timeframe, and any unopened food item will be discarded by the manufacturer labeled expiration date.The policy reviewed 07/1999 titled Personal Hygiene documented employees must follow personal hygiene practices and must wear hair restraints required by state or federal health codes. During observation of the kitchen on 12/16/2025 at 12:27 PM, the following was revealed:The reach- in refrigerator contained unlabeled and undated fruit salad, sliced cucumbers, crumbled bacon, a tray of uncovered plated tossed salads, squeeze bottles of salad dressings, a pitcher of tomato juice, cheese, a plastic bag of whipped topping stored in a paper cup. The walk-in refrigerator contained unlabeled and undated macaroni and cheese and sliced turkey. The freezer contained undated and unsealed bags of French fries and green beans. The reach-in refrigerator contained almond milk with an 11/29/2025 expiration date, chocolate milk with a 12/11/2025 expiration date, three (3) individual cartons of milk with a 12/08/2025 expiration date, cranberry juice with a 12/01/2025 expiration date, and coleslaw with an 11/20/2025 expiration date. The walk-in cooler contained coleslaw with an 11/20/2025 expiration date. The emergency food supply pantry contained a case of expired Corn Flakes and a case of expired Scooter cereal. Staff were observed walking through the kitchen without wearing hair restraints, and a cook without a beard guard prepared to work with raw chicken. During interview with the Corporate Food Service Director on 12/16/2025 at 12:27 PM they stated staff without hair nets were independent living restaurant wait staff, were not preparing food and were not required to wear hairnets. The Corporate Food Service Director asked the cook to apply and wear a beard guard. The Corporate Food Service Director stated the former Food Service Director was responsible to ensure staff labeled and dated food, disposed of expired food, and monitoring the use of hair and beard restraint. The Corporate Food Service Director stated they were the acting Food Service Director effective that day and were responsible for the kitchen staff due to the former Food Service Director leaving without notice.10 NY CRR 415.14(h)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review the facility did not ensure that each resident was treated in a manner that maintained or enhanced each resident's dignity and respect for one (1) resident (Resident #32) reviewed for dining. Specifically, Resident #32's meal tray and feeding assistance were not provided at the same time another resident (Resident #23) at the same table was provided their meal tray and feeding assistance. Additionally, once served, Registered Nurse #18 stood over Resident #32 while they provided the resident with feeding assistance.The findings include:The policy titled Resident Rights last revised 11/2025 documented residents have the right to a dignified existence. Residents will be treated with respect and dignity, and cared for in a manner, and in an environment that promotes the maintenance or enhancement of their quality of life and recognizes their individuality. During an observation in the dining room on December 16, 2025, at 5:27 PM, while their tablemate, Resident #32, was waiting to be served, Resident #23 was served and eating their dinner with assistance. Resident #32 received their dinner at 5:33 PM. Then, while standing over the resident, Registered Nurse #18 provided Resident #32 with feeding assistance.During a telephone interview on 12/22/2025 at 2:47 PM, Registered Nurse #18 stated they did not receive specific orientation about dining or assisting with feeding. They stated they stood when assisting residents because it was easier for them to observe the resident and check if any food was dropping. During an interview on 12/22/2025 at 3:15 PM, the Food Service Director stated residents at the same table should be served their meal at the same time. They stated they were trying to better coordinate that process. During an interview on 12/22/2025 at 3:28 PM, the Director of Nursing stated that residents at the same table should be served their meals together. They stated staff should not stand while they assisted residents with eating.10NYCRR 415.3(d)(1)(i)

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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. Based on record review and interview the facility did not ensure the development and implementation of comprehensive person-centered care plans that included measurable objectives and timeframes to meet the resident's medical, nursing, and nutrition needs for one (1) of one (1) resident (Resident #20) reviewed for Tube Feeding. Specifically, there was no documented evidence that a comprehensive care plan with goals and interventions was developed to address Resident #20's tube feeding and nothing by mouth status as per the 11/29/2025 physician order. The findings include:The policy and procedure revised 08/2025, titled Resident Assessment and Comprehensive Care Planning documented a comprehensive care plan includes measurable objectives to meet each identified problem/need and is reviewed and revised as necessary to outline care needs and strategies. Professional staff individualizes each care approach specific to each resident's needs.Resident #20 was admitted to the facility with diagnoses including Parkinson's disease, and dysphagia.The 04/16/2024 care plan titled Alteration in Nutrition/Hydration documented document percentage of food eaten at each meal; open containers; provide special utensils as needed and to allow adequate time to eat and feed Resident #20 remaining food items at meals. The 11/29/2025 physician order documented nothing by mouth and tube feeding of Jevity1.2 calories at 70cc (cubic centimeters equivalent to one milliliter) per hour for 20 hours. The 12/05/2025 Significant Change Minimum Data Set (a resident assessment tool) documented Resident #20 was cognitively intact, dependent with eating, and had a feeding tube that provided 51% or more calories from the feeding tube. There was no documented evidence of a care plan to address tube feeding and that Resident #20 was no longer taking food by mouth. During observations on 12/16/2025 at 1:25 PM and 12/17/2025 at 1:09 PM, Resident #20 was observed in bed with tube feeding running at the rate of 70 cc. During an observation and interview on 12/18/2025 at 12:02 PM, Registered Nurse #9 prepared to hang the tube feeding formula and administered 300 cc water bolus and two (2) crushed tablets through the feeding tube. They stated Resident #20 was ordered to have nothing by mouth and the water and tablets were to be given via the feeding tube. During an interview on 12/18/2025 at 1:21 PM, the Registered Dietitian presented a progress note which documented Resident #20 received all nutrition from the tube feeding. They stated they were unable to produce a care plan that addressed tube feeding and that Resident #20 was to have nothing by mouth. During an interview on 12/22/2025 at 1:41 PM, the Director of Nursing stated there should have been a tube feeding care plan to include the type of formula, rate of feeding and that the resident received nothing by mouth since the feeding tube was the sole method of nutrition for the resident. 10 NYCRR 415.11(c)(1)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. Based on record review and interview the facility did not ensure that medical supervision was provided for one (1) of three (3) residents (Resident #11) reviewed for pressure ulcers. Specifically, Resident #11 was diagnosed with a left heel Stage 2 pressure ulcer, and the primary physician did not address recommendations by the wound care physician on 11/25/2025 or 12/02/2025 or 12/09/2025. Subsequently, two (2) weeks later Resident #11's left heel wound was classified as unstageable, was surgically debrided on 12/09/2025 and then classified as a Stage 4 pressure ulcer (full thickness skin and tissue loss).The findings include:The 3/28/2019 policy titled Pressure Ulcer Prevention and Management documented the physician writes orders for treatments as needed.Resident #11's diagnoses included status post left hip fracture with surgical intervention, osteoporosis, and non-Alzheimer's dementia. The 11/12/2025 Comprehensive Nursing Assessment (admission assessment) documented Resident #11 was at risk for pressure ulcers. The 11/12/2025 Braden Scale (tool for predicting pressure ulcer risk) documented Resident #11 was at risk for pressure ulcers.The 11/19/25 admission Minimum Data Set (resident assessment) documented Resident #11 had no pressure ulcers present on admission and was at risk for developing pressure ulcers.The 11/23/2025 Registered Nurse #19's progress note at 11:02 PM documented Resident #11's left heel blister was open with large amount of serous drainage present. The wound was beefy in color with a darkened center measuring 2.5 by 2.5 by 0 centimeters. The area of wound measured 5 by 4 by 0 centimeters. The physician was notified, treatment ordered and applied; the resident to be followed by the wound physician on Tuesday. The 11/25/2025 Wound Evaluation & Management Summary documented a Stage 2 pressure ulcer on the left heel measuring 4.5 by 3.2 by 0.1 centimeters, with good healing potential. The recommended treatment was alginate calcium once a day and as needed, gauze island with border once a day, cleanse with normal saline. General recommendation included offload wounds, float heels in bed, turn side to side in bed. Specific to visit recommendations included nutritional shakes three times a day with meals, and offloading Darco shoes (used to support and offload pressure from the foot). There was no documented evidence in the physician's orders to address the 11/25/2025 wound evaluation recommendations to offload wounds, float heels in bed, turn side to side in bed, or nutritional shakes three times a day with meals.The 12/02/2025 Wound Evaluation & Management Summary documented a Stage 2 pressure ulcer on the left heel measuring 4.2 by 3.5 by 0.1 centimeters, and good healing potential. General recommendations included offload wounds, float heels in bed, turn side to side in bed and specific recommendations included nutritional shakes three times a day with meals, and offloading Darco shoes.There was no documented evidence in the physician's orders to address the 12/02/2025 wound evaluation recommendations to offload wounds, float heels in bed, turn side to side in bed, and nutritional shakes three times a day with meals. The 12/09/2025 Wound Evaluation & Management Summary documented the resident was seen for a Stage 4 pressure ulcer of the left heel, full thickness. Wound size 3.2 by 3.5 by 0.1. centimeters. Surface area 11.2-centimeters, open ulceration area of 10.08 centimeters, light serous exudate, 90% thick adherent devitalized necrotic tissue, 10% intact normal skin color.There was no documented evidence in the physician's orders to address the 12/09/2025 wound evaluation recommendations to offload wounds, float heels in bed, turn side to side in bed, or nutritional shakes three times a day with meals.There was no documented evidence that protein supplements were ordered until 12/19/2025.During an interview on 12/22/2025 at 2:30 PM, the Primary Physician stated the facility process was that the registered nurse unit manager or another nurse or the director of nursing should contact them with the wound physician recommendations. They stated they usually agreed with and gave orders for all the wound care physician recommendations. The Primary Physician stated the process was that nurses entered the orders for the recommended interventions after the primary physician agreed with the recommendations. They stated they reviewed Resident #11's wound consults including the recommendations and signed the 11/25/2025, 12/02/2025, and 12/09/2025 (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wound consults. The Primary Physician stated they thought the nurse/s placed orders for floating Resident #11's heels/offloading Resident #11's heels in bed, turning and positioning in bed, and nutritional shakes.10 NY CRR 415.15(b)(1)(i)(ii)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335802	A. Building B. Wing	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glen Arden Inc	214 Harriman Drive Goshen, NY 10924

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 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on interview and record review the facility did not ensure that certified nurse aides had a performance review completed every 12 months. Specifically, one (1) of four (4) certified nurse aides (Certified Nurse Aide #5) did not have a performance review completed in the last twelve months.The findings include:There was no documented evidence of a completed annual performance review for Certified Nurse Aide #5 in the last 12 months. During an interview on 12/19/2025 at 12:45 PM, Registered Nurse Unit Manager #4 stated they were responsible for completing the annual reviews for the staff nurses, nurse supervisors, and certified nurse aides. They stated Certified Nurse Aide #5 worked with the facility since 09/24/2018. They stated they did not have a signed performance review for Certified Nurse Aide # 5 from the last 12 months.During a follow up interview on 12/22/2025 at 1:05 PM, Registered Nurse Unit Manager #4 stated they contacted Human Resources and determined they did not have a performance review on file for Certified Nurse Aide #5 from the last 12 months. 10NYCRR 415.26(c)(2)(iii)