STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335806	A. Building B. Wing	04/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springvale Nursing & Rehabilitation Center	67 Springvale Road Croton on Hudson, NY 10520

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on record review and interview during an abbreviated survey (NY00355663) the facility did not ensure the resident representative was immediately informed of a significant change in the resident's physical status or a need to alter treatment significantly for 1 of 3 residents (Resident #1) reviewed for notification of changes. Specifically, Resident #1's representative was not notified when the resident had a Midline Catheter (Intravenous Catheter) inserted. Findings include: The facility notifications policy dated 1/2017 last reviewed 1/2025 documented the clinical nurse will recognize and appropriately intervene in the event of change in resident's condition. The facility will notify the resident, attending physician and representative of changes in the resident's condition and or status. Resident #1 had diagnoses including dementia, end stage renal disease, and coronary artery disease. The Quarterly Minimum Data Set (MDS) (assessment tool) dated 8/14/24 documented the resident had severely impaired cognition. The resident required moderate to maximal assistance for all activities for daily living. The Physician Order dated 9/27/2024 documented to place a Midline Catheter (catheter in the vein to administer fluids). The Nursing Progress Note from 9/27/2024 through date of discharge did not document the Midline Intravenous Catheter was placed. The Invoice from an intravenous contracting company documented a Midline Intravenous Catheter was inserted for Resident #1 on 9/27/2024. There was no documented evidence from 9/27/2024 thru discharge that Resident #1's representative was notified of a Midline Intravenous Catheter being inserted. During an interview on 3/18/2025 at 4:00 PM, Registered Nurse Manager #1 stated they remembered the physician ordered Intravenous Medication. They had attempted to place a Peripheral Intravenous Catheter but were unable. The intravenous contracting company was called to place the intravenous line. They did not remember if the resident representative was notified. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/19/2025 at 9:48 AM, the Assistant Director of Nursing stated if the resident had an intravenous line inserted, the representative should have been notified and there should have been a progress note. During a telephone interview on 3/20/2025 at 10:45 AM, Resident #1' Representative stated they were unaware the resident had a Midline Catheter inserted until they saw the resident in the emergency room of the hospital on 9/28/2025. The representative further stated the facility did not notify them or any other family member. During an interview on 3/20/2025 at 2:50 PM, the Nurse Practitioner stated they did not recall speaking with Resident #1's family, they expected the Unit Manager to notify the resident's representative when the Midline Catheter was placed. 10 NYCRR 415.3(f)(2)(ii)(b)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on record review, and interview conducted during the abbreviated survey (NY00352849) the facility did not ensure that residents remained free from abuse for one of three (Resident #7) reviewed for Abuse. Specifically, for Resident #7 with documented ongoing aggressive behaviors and refusal of medication/s, there was no documented evidence that care plan interventions were evaluated to determine effectiveness to ensure resident safety. Subsequently, on 8/28/2024 Resident #7 propelled their wheelchair hitting another resident as staff assisted the other resident up off the floor and on 9/4/2024 Resident #7 struck Resident #10 in the stomach which caused a fall and resulted in Resident #10 sustaining a left side hematoma of the head, right wrist fracture, left femoral intertrochanteric (hip) fracture. The findings include: Resident # 7 had diagnoses including dementia, anxiety disorder, and psychotic disorder. The 9/20/2023 Care Plan tited At Risk for Abuse documented identify pattern of behaviors and redirect negative behaviors. The care plan was updated on 8/29/2024 to include administer medications as per physician order, and 9/4/2024 notify and report behavior changes to the physician. The 6/18/2024 Care Plan titled Behaviors documented identify behavioral patterns, orient the resident to the daily routine, redirect negative behaviors, and notify the physician of any changes in behavior. The 08/18/2024 quarterly Minimum Data Set (an assessment tool) documented Resident #7 had severe cognitive impairment, did not exhibit behavior and received antipsychotic and antidepressant therapies. The 8/20/2024 Nursing Progress Note documented the resident was at the nursing station very agitated screaming/shouting with provocation. Verbal redirection and de-escalation was unsuccessful. Refused by mouth medications. Attempt to hit residents and staff with items, moved to their room. Resident flipped the wheelchair and attempted to move the bed in the room. Physician made aware. Order received for Ativan 1 mg 1 time dose. Behavior improved. Continue monitoring mood and behavior, safety maintained. The 8/20/2024 Physician Order documented Ativan 2 mg inject 0.5 ml intramuscularly one time. The 8/21/2024 Nursing Progress Note documented refused medications despite encouragement. The 8/26/2024 Nursing Progress Note documented behavioral issue refused medications. The 8/27/2024 Behavior Note documented continues to yell/scream and pour water on the floor. Kicking/screaming and intrusive towards others. The 8/27/2024 Medical Progress Note documented no behavioral concerns from staff-has been agitated and paranoid. Medications reviewed, stable continue current treatment. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 8/28/2024 Accident and Incident Investigation documented at 10:00 PM. Resident #7 had physical contact with another resident, identified as Resident #11. Certified Nurse Aide #6 provided a written statement indicating that Resident #7 accidentally bumped into Resident #11 while propelling their wheelchair. Additionally, a review of the Accident and Incident form from 8/28/2024 revealed that an 11:00 PM-7:00 AM 30-minute monitoring check for Resident #7 was in place. Immediate action residents were separated, and behavioral monitoring initiated. The 8/29/2024 Psychiatrist Progress Note documented this writer was asked to see the resident after an incident with another resident yesterday in which they propelled their wheelchair toward another resident. On interview the resident stated the other resident went into their room and was harassing them. Plan if violent or aggressive in the future please send to the emergency room for evaluation. Recommendations: supportive behavioral interventions, structured recreational activities, strict but supportive limit setting and continued medications. The 8/29/2024 Physician Order documented Seroquel 50 mg by mouth now. The 8/30/2024 Nursing Progress Note documented continues every 30-minute rounds. The 8/30/2024 Nursing Progress Note documented refused all medication, nurse practitioner aware, no new orders. The 8/30/2024 Medical Progress Note documented staff tried to educate the resident on importance of taking medications and the resident responded, yelling they did not need medications. Will continue to explain to the resident as to why they need medications when they are calmer. If the behavior continues the resident was to be evaluated by psychiatry. The 9/1/2024 Nursing Progress Note documented the resident refused to take medications and was aggressive with staff and residents. The 9/2/2024 Physician Order documented Ativan 2 mg inject 0.5 ml intramuscularly one time. The 9/4/2024 Accident and Incident Investigation Statement written by the nurse documented as they were at the nursing station Resident #10 appeared to walk towards Resident #7 then Resident #7 appeared to push Resident #10 to the ground and Resident #10 fell on their right side and had a knot on the right side of the head. The Summary /Conclusion documented on 9/4/2024 at 8:10 AM Resident #10 was walking in the hallway when they walked over and stood in front of Resident #7 who was sitting in a wheelchair in front of the nursing station. Resident #7 attempted to have Resident #10 leave when they accidentally struck Resident #10 in the stomach with their hands. Resident #10 lost their balance and fell to the floor, sustaining a quarter size hematoma to the left side of the forehead, no open area. Resident #10 was sent to the emergency room for evaluation and Resident # 7 was sent to the emergency for psychiatric evaluation. The incident was most likely unintentional since there was no verbal exchange prior or post incident. Resident #10 sustained a right wrist fracture and left intertrochanteric fracture from the fall. There was no documented evidence that Care Plans for Resident #7 were evaluated to determine effectiveness. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/20/2025 at 8:15 AM Certified Nurse Aide #6 stated it was difficult to watch all the residents at times. They stated the home health aides helped to monitor the residents to prevent them from going into other resident rooms and staff often redirected residents to where their rooms were. They stated staff tried to keep residents in the dayroom when they were up. During an interview on 3/20/2025 at 11:14 AM the Director of Recreation stated the resident usually stayed at the nursing station and did not actively participate in activities with other residents. They stated they tried to engage the resident, but the resident had verbal outbursts. They stated the resident behaviors were from too much sensory overload, chaotic environment on the dementia/behavioral unit and to move to another unit was better for the resident. During an interview on 4/18/2025 at 10:40 AM, Registered Nurse Unit Manager #3 stated the behavioral care plan for the resident had not been updated with any new interventions following the incident on 8/28/2024. They stated that behavioral symptoms were monitored on 9/4/2024. The manager stated certified nurse aides were responsible for monitoring residents for physical and aggressive behavior and reporting observations to the nurse. During an interview on 4/18/2025, at 10:55 AM, the Assistant Director of Nursing stated Resident #7 was on behavior monitoring for 30 minutes following an altercation with another resident on 8/28/ 2024 and they were evaluated by psychiatry on 8/29/2024. They stated the care plan for the resident included continue medications, along with regular structured activities that included support and set limits. They stated Resident #7's behavior care plan had not been updated with new interventions after the incident on 8/28/2024. They stated staff members rounded on the resident's unit to monitor behavior, but they were unable to locate the monitoring sheets for that resident. During an interview on 4/18/2025 at 1:45 PM, the Psychiatric Nurse Practitioner stated when Resident #7 deviated from baseline or showed signs of escalation they recommend the resident be sent to the hospital for evaluation. They stated when observed by them, Resident #7 was always in bed and did not display aggressive behavior. They stated the facility should have implemented behavioral interventions to address the needs of the resident. During a telephone interview on 4/21/2025 at 2:41 PM, the Director of Social Work stated there was a delay in moving Resident #7 from the behavior unit due to a lack of available beds. The Director of Social Work stated staff did their best to support the resident and ensure the safety of all residents by closely monitoring activities. 10 NYCRR 415.12 (h)(1)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review conducted during an abbreviated survey (NY00331614) the facility did not ensure that all alleged violations of abuse were reported immediately, but not later than 2 hours to the state survey agency for 1 of 3 residents reviewed for Abuse (Resident #5). Specifically, Resident #5 made an accusation of abuse on 1/15/2024 and that was not reported to the state agency until 1/17/2024. In addition, there was no documented evidence of the 5-day investigation report submission to the Department of Health either. Findings included: Resident # 4 had diagnoses including bipolar disorder, paranoid schizophrenia, and schizoaffective disorder. The admission Minimum Data Set, dated [DATE] documented moderately impaired cognition, with behaviors, and required moderate-maximum assistance with activities of daily living. The Investigation Report documented that Resident #5 called 911 on 1/15/2024 at 6:00AM and made an allegation of being beaten and raped. Law enforcement and paramedics responded to the call, and the resident was transferred to the hospital for evaluation. The allegation was documented as reported to the Department of Health on 1/16/2024 without a time indicated. The hospital report dated 1/15/2024 documented Resident #5 was examined at 7:22AM and there was no evidence of trauma, exam unremarkable aside from bizarre thought process, endorsed to telepsychiatry for evaluation. During an interview on 3/20/2025 at 1:50PM, the Administrator stated that the Director of Nursing and Assistant Director of Nursing completed the investigations. The Director of Nursing that was employed at the time of the incident is no longer at the facility. Allegations of Abuse are to be reported within 2 hours after the allegation has been made. During a telephone interview on 3/28/2025 at 1:20PM, the Assistant Director of Nursing stated they could not locate the submission information for the incident on 1/15/2024. The Director of Nursing who is no longer employed at the facility had reported that incident. The Director of Nursing would have submitted the investigation report as well, but they could not provide a confirmation number of that submission. They stated that allegations of abuse should be reported to the Department of Health within 2 hours and the investigative report should be submitted within 5 days depending on the case and if requested. 10 NYCRR 415.4(b)(2)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review during an abbreviated survey (NY00332451), the facility did not ensure that 1 of 3 residents (Resident #4) investigated for abuse received treatment and care in accordance with professional standards of practice, the comprehensive care plan, and resident preferences to promote mental, and psychosocial well-being. Specifically, on 1/29/24, Resident #4 made an allegation of abuse. The Accident and Incident report, nursing notes and care plans documented a referral to psychiatry was made. There was no documented evidence that the referral was completed. The findings included: Resident # 4 had diagnoses that included, but were not limited to status post fall and right elbow injury triad, alcoholic cirrhosis, and hypertension. The Comprehensive Care Plan titled At Risk for Abuse dated 9/21/23 documented the resident will show no signs or symptoms of abuse. The Physician Order dated 9/21/23 documented Psychiatric Consult as needed. The admission Minimum Data Set, dated [DATE] documented intact cognition and no behaviors. The Nursing Progress Note dated 1/29/24 documented Resident#4 reported a rough interaction with the Certified Nursing Aide that provided their cares on 1/29/24. The resident was assessed by the Nurse Practitioner; no overt injury noted. Psychiatric referral made. The Medical Progress note dated 1/29/24 documented no apparent injuries observed during resident assessment. The Certified Nursing Aide was immediately removed from the unit while further investigation was completed. The Accident/Incident Report dated 1/29/24 documented Resident #4 alleged rough handling by the Certified Nursing Assistant during cares on 1/29/24. Registered Nurse assessment completed. Physician orders received for Psychiatric and Social Services follow up. The Investigation portion of the report documented that the immediate actions taken included requesting a Psychiatric Consult. There was no documented evidence of a psychiatric referral or consult related to the incident. The Comprehensive Care Plan titled At Risk for Abuse revised 1/29/24 documented the intervention to refer for psychiatric consultation. During an interview on 3/20/25 at 10:20AM, Psychiatric Nurse Practitioner #4 stated that they only completed one consultation for Resident #4 on September 30, 2023. After an accusation of abuse, they would expect a psychiatric consultation to be requested. They did not receive a referral after the 1/29/24 incident or any other time after. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/20/2025 at 10:45AM with Licensed Practical Nurse Unit Manager #7 stated when a Psychiatric Consultation is requested for a resident and an as needed order for a Consultation is already in place, they send a message to the Director of Nursing to add the resident to the list for the Psychiatric Nurse Practitioner. After the Psychiatric Nurse Practitioner visits, they are informed who as to who was seen. If a visit is missed, they put them back on the list. They were not employed at the facility when Resident #4 was there, so they were not able to provide a reason why the Consultation was not completed. During an interview on 3/20/25 at 12:55PM, Nurse Practitioner #3 stated that they could not recall the specific reason why a Psychiatric Consultation was not performed for Resident #4 after the incident on 1/29/24. They stated they would have requested the consultation given the circumstances of the allegation and there should have been documentation as to why the consultation was not completed. During an interview on 3/20/25 at 3:10 PM, the Director of Nursing stated that they were not employed at the facility at the time of the incident, however after an allegation of abuse they would expect a referral for a psychiatric consultation. During an interview on 3/20/25 at 3:20PM, Registered Nurse Assistant Director of Nursing #2 stated that they remember that Psychiatric referral was made at the time of the incident, but uncertain of specific circumstances as to why it was not done. 10 NYCRR 415.12