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	08/15/2025

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 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, interview, and record review, conducted during the recertification survey from 8/11/2025 to 8/15/2025, the facility did not ensure proper storage, preparation, distribution, and service of food in accordance with professional standards for food safety. Specifically, 1) undated cheese and juice was stored in the refrigerator; 2) ground meat and vegetables were not dated; and 3) Food Service Workers did not wear hairnets and beard guard to prevent hair from contacting food. The findings include: A facility policy dated 5/2023 and titled Dating and Labeling Policy documented the kitchen will ensure food safety by maintaining proper dates and labels to all goods and ready to eat food products. The procedure includes label products in storage with date the package was opened, ready to eat foods must be dated with a 72-hour use by date and discarded when expired. A facility policy dated 5/2023 titled Uniform Policy documented the kitchen will ensure that Food and Nutrition department employees represent a tidy, clean professional appearance and wear a uniform that meets the established guidelines of the department. Hair nets are to be worn and completely cover hair from front to back. Facial hair coverings will be worn to cover facial hair over a 1/4 inch in length. 1) During a tour of the main refrigerator on 8/11/25 at 7:00AM, six slices of yellow cheese were observed on a shelf without a date and a pitcher of juice next to the cheese was not labeled and dated. During an interview on 8/11/25 at 7:00AM, Food Service Worker #23 stated all food should be dated and labeled and they did not know why these two items were not properly stored. 2) During an observation on 8/11/25 at 7:05AM, a small container of warmed meat and a container of warming vegetables was observed on top of a stove without a date. Writing on the plastic wrap documented for Monday but not dated. During an interview on 8/11/25 at 7:15 AM, [NAME] #42 stated they wrote for Monday on the plastic wrap on the meats and vegetables because it was for Monday lunch and they did not want anyone to use it for something else. They stated it was prepped the day before (Sunday). During an interview on 8/11/25 at 1:41 PM, the Director of Food Services stated all food in the refrigerators needed to be dated when it was opened. They did not know why the juice and cheese was not dated. They thought it might have been about to be used for the breakfast meal, and someone put it in the refrigerator temporarily. There was a routine for the refrigerator, and it was checked for (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	undated and expired food daily. All other foods including meats and food prepared ahead of time needed to be dated with the date it was prepared. In this case Cook#42 wrote a message instead of the date. 3)During the initial tour of the kitchen on 8/11/25 at 6:55 AM, Food Service Worker #21 and #22 were observed without hairnets in place in an area where breakfast food was beginning to be plated. Food Service Worker #21 and#22 were asked why they were not wearing a hairnet, and both said they forgot to do this but should have done it before entering the kitchen. During an observation on 8/12/25 at 11:19AM Food Service Worker#24 was observed walking up to the steam tray, donning gloves and grabbing utensils, removing plastic wrap from food pans about to start the service. They had full facial hair covering both cheeks and chin; their skin was not visible through hair. They were asked why they were not wearing a cover for their beard and immediately was pulled off the line by the Director of Food Service. During an interview on 8/12/25 11:30AM with the Director of Food Service they stated they were responsible for making sure staff were ready for service which included making sure hairnets and beard guards were in place but missed it. They further stated that they had instructed all the dietary service staff to wear a hairnet when entering the kitchen. 10NYCRR 415.14(h)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review conducted during the recertification and abbreviated (NY00359686) survey from 8/11/2025 to 8/15/2025, the facility did not ensure the resident's representative was notified when there was a need to alter the resident's treatment and transfer the resident from the facility. This was evident for 1 (Resident #194) of 4 residents reviewed for notification of change. Specifically, Resident #194's representative was not notified when the resident received intravenous hydration and was transferred to the hospital. The findings are: The facility policy titled Change in Condition dated 5/2025 documented the facility will notify the resident representative of changes in the resident's condition. Documentation of a change in the resident's condition is encouraged. Resident #194 had diagnoses of cerebral infarction (stroke) and colon neoplasm (cancer). The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #194 was moderately cognitively impaired. The Nursing Note dated 10/17/2024 documented Resident #194 had an episode of emesis and a stat abdominal x-ray was ordered. The Nurse Practitioner Note dated 10/17/2024 documented Resident #194 was administered zofran to address their nausea and vomiting and was started on intravenous hydration. The Nursing Note dated 10/18/2024 documented Resident #194 received an intravenous hydration infusion and antibiotic for a urinary tract infection. There was no documented evidence Resident #194's Representative was notified of the resident's need for intravenous hydration or antibiotic therapy. The Nursing Note dated 11/27/2024 documented Resident #194 was sluggish, had a change in mental status, and was transferred to the hospital for evaluation. There was no documented evidence Resident #194's Representative was notified of the resident's need for hospitalization. On 8/12/2025 at 11:33 AM, a telephone interview was conducted with the resident's representative who stated Resident #194 had several changes in condition and was hospitalized during their stay in the facility in 10/2024 and 11/2024. Resident #194's representatives were not informed of all the changes that occurred with the resident while at the facility. On 8/15/2025 at 9:32 AM, Licensed Practical Nurse #3 was interviewed and stated the Licensed Practical Nurses, Registered Nurses, Nurse Practitioner, and/or Medical Doctor were responsible for contacting a resident's representative and/or next of kin when there were changes in a resident's condition or was hospitalized . Resident representatives were also informed if a resident was sluggish and lethargic or had a change in vital signs. Any changes in medication orders and new orders of antibiotic therapy were also communicated to a resident's representative. The nursing staff who informed a resident's representative of changes or hospitalization were responsible for writing a note documenting the notification in the resident's medical record. On 8/14/2025 at 3:46 PM, the Medical Director was interviewed and stated the nursing staff were responsible for contacting a resident's representative and informing them of a change in the resident's condition or hospitalization. The Medical Director stated the Nurse Practitioner or Medical Doctors communicated with and notified resident representatives of changes in a resident's condition if there was a complicated or serious issue to address. On 8/15/2025 at 11:32 AM, the Director of Nursing was interviewed and stated they began working for the facility approximately 2 months ago and implemented chart auditing to improve staff documentation in the medical records. The licensed nurses, Medical Doctors, and Nurse Practitioners were all responsible for notifying a resident's representative when there were changes in a resident's condition and documenting in the medical record upon communication with the representative. 10 NYCRR 415.3(f)(2)(ii)(c-d)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review conducted during the recertification and abbreviated (NY00359686) survey from 8/11/2025 to 8/15/2025, the facility did not ensure a safe environment with protection of a resident's property from loss or theft. This was evident for 1 (Resident #194) of 6 residents reviewed for personal property. Specifically, Resident #194's personal cell phone went missing and was unable to be found during their stay at the facility. The findings are: The facility policy titled Inventory/Personal Belongings dated 1/2025 documented each resident will be offered/provided a locked drawer or equivalent with a key for small valuables. Resident #194 had diagnoses of cerebral infarction and schizoaffective disorder. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #194 was moderately cognitively impaired. The Social Work Note dated 10/14/2024 documented Resident #194 reported their phone went missing while being charged. The note documented the Director of Social Work discussed the matter with Resident #194's family member. There was no documented evidence Resident #194's cell phone was protected from loss and/or theft in 10/2024. On 8/12/2025 at 11:33 AM, a telephone interview was conducted with the Complainant who stated Resident #194's cell phone and clothing went missing at the facility in 10/2024. There was direct communication with the Administrator regarding the facility's investigation into matter. On 8/14/2025 at 10:15 AM, the Director of Social Work (and Grievance Official) was interviewed and stated they began working for the facility in 7/2024. Clothing brought to the facility was labeled by Housekeeping and documented on an inventory checklist form. A copy of the form was kept on file in the Housekeeping Department and a copy was given to the resident and/or resident's family. The forms were kept at the front desk for easy access to resident families. The Director of Social Work stated, if a resident lacked capacity, the nursing staff would take possession of a resident's valuables for safekeeping and sometimes gave the valuables to the Director of Social Work for safekeeping. Some residents and their families were adamant about a resident maintaining possession of their valuables, i.e. a cell phone. The Director of SOcial Work stated they were able to offer residents access to their cell phone kept locked in the Social Work Office on a limited basis. The Director of Social Work stated they were unaware whether Resident #194 was offered a personal storage area or lockbox for their cell phone in 10/2024 and would check with the Housekeeping Department for copies of Resident #194's inventory checklists. On 8/15/2025 at 9:32 AM, Licensed Practical Nurse #3 was interviewed and stated some residents had a bedside dresser drawer equipped with a lock for valuables and the Maintenance Department could be contacted to obtain a lockable dresser drawer for residents without one in their room. The residents were able to hold onto the keys for these drawers, or the licensed nurses could hold onto the keys if the residents were unable to do so. On 8/15/2025 at 11:13 AM, the Administrator was interviewed and stated residents were allowed to maintain possession of their cell phones and had their possessions documented on a personal property inventory checklist. The Administrator stated they could not recall the details of Resident #194's missing cell phone. Each resident had access to a lockable dresser drawer in their room to keep their valuables safe. 10 NYCRR 415.29(c)(4)

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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 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 interviews and record review during the recertification and abbreviated surveys (2564017) from 08/11/2025-08/15/2025, the facility did not ensure that all alleged violations involving abuse or mistreatment, were reported to the Administrator of the facility immediately or within two (2) hours after the allegation was made for one of five (1 of 5) residents reviewed for abuse. Specifically, Resident #200's daughter made an allegation of verbal mistreatment/abuse by a staff member, but staff did not report the allegation to the Administrator or State Agency. Findings include:The facility Abuse Policy-Prevention and Management last reviewed 08/2025 documented that the facility has designed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident/patient abuse, neglect, mistreatment, and/or misappropriation/exploitation of property. Oral, written, or gestured language, that willfully includes disparaging and derogatory terms, to the resident/patient or their families, or within their hearing distance, to describe resident/patient, regardless of their age, ability to comprehend or disability. The Shift Supervisor/Charge Nurse is identified as responsible for immediate initiation of the reporting process. The Administrator, Director of Nursing, and Risk Manager, if applicable are responsible for investigation and reporting.Resident #200 had diagnoses that included, but were not limited to, cancer, renal insufficiency, and diabetes mellitus. The Five Day Minimum Data Set, dated [DATE] documented moderately impaired cognition and no behaviors. There was no documented evidence of any grievances from Resident #200 or their family in the 2025 grievance log/book.There was no documented evidence of any incident reports for Resident #200 or their family in 02/2025 or 03/2025.There was no documented evidence of a progress note describing the incident. During a telephone interview on 08/14/2025 at 9:36 AM, Resident #200's family member stated that there was an incident involving Licensed Practical Nurse #5 when their mother, Resident #200, was a resident at the facility from 02/2025-03/2025. They stated Licensed Practical Nurse #5 was verbally insulting and used foul and inappropriate language that was directed toward them and Resident #200. They stated that they did attempt to speak with multiple staff about the incident and there were two (2) staff witnesses to the event. The facility never addressed the issues or responded to them when they asked what was being done. During an interview on 08/14/2025 at 3:23PM, the Director of Human Resources, reviewed the employee file for Licensed Practical Nurse #5 with this surveyor. Their performance reviews dated 05/15/2024 and 03/13/2025 documented that they passed their evaluations. There were no documented disciplinary actions in their file. They stated if a resident, family member, or staff witness mistreatment or receive an allegation of abuse, they had multiple avenues to report the occurrence, such as social services, human resources, and administration. Staff received education on abuse, allegations of abuse, and reporting any misconduct. During an interview on 08/15/2025 at 9:26 AM, Registered Nurse Unit Manager #2 stated that they were the covering Unit Manager on 1 [NAME] once a week. If there was an allegation of abuse, they would stop the incident, report the incident, and complete the necessary documentation. They were mandated to report all allegations of abuse. They were not witness to, or aware of, any inappropriate verbal interaction between staff and Resident #200 or their family. If there was an allegation, they would document something in the progress notes and report the incident. During an interview on 08/15/2025 at 10:15 AM, Licensed Practical Nurse #5 stated they did remember Resident #200 and the incident in question. They stated that they were passing Resident #200's room that day and made a comment to fellow staff members in the hallway about a conversation they were having about women being crazy. The staff were joking with each other. The family member thought the comment was directed at them. The family member followed them and argued with them in the hallway. Registered Nurse Unit Manager #10 advised them (Licensed Practical Nurse #5) to walk away from the family member. They (continued on next page)

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	335806	A. Building B. Wing	08/15/2025

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completed a statement and gave it to Registered Nurse Unit Manager #10. They did not remember ever discussing the incident with Administration. During an interview on 08/15/2025 at 10:52 AM, the Director of Nursing stated they were not employed at the facility when Resident #200 was at the facility. They had not had any interaction or conversations with the family member since they started and were not aware of any incidents involving Resident #200 and staff. During an interview on 08/15/2025 at 11:10 AM, the Director of Social Work stated Resident #200's family member did report the incident in question to them involving Licensed Practical Nurse #5. They did not know that the family member felt it was directed at the resident as well. They did discuss the event with the family member, and they thought it was resolved. However, when the family member returned to the facility after Resident #200 passed away, they brought up the incident again and wanted to know what was done about it. They stated they relayed the family member's concern to Administration. They were not certain what happened after that. If there was an allegation of abuse, it should have been reported. During an interview on 08/15/2025 at 11:35 AM, the Administrator stated that they never received any reports of any incidents between Licensed Practical Nurse #5 and Resident #200 or their family. They should have been notified so they could have investigated the allegation and reported if necessary.10 NYCRR 415.4(b)(2)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interviews and record review during the recertification survey on 8/11/2025 to 8/15/2025, the facility did not ensure that the resident, resident's representative(s), or representative of the Office of the State Long-Term Care Ombudsman (an official patient advocate not hired by the facility) was notified of the transfer or discharge, and the reasons for the move, in writing and in a language and manner they understand for 2 of 3 residents (Resident #189 and Resident #191) reviewed for hospitalization and discharge. Specifically, 1) the facility did not complete a discharge notice or notification of bed hold for Resident #189 when they were hospitalized . The ombudsman was not notified of Resident #189's transfer/discharge to the hospital; 2) The Ombudsman was not notified of Resident # 191's discharge to the community. Findings include:1. Resident #189 had diagnoses that included Alzheimer's disease, Cerebrovascular Accident (CVA) and atrial fibrillation. The admission Minimum Data Set (an assessment tool) dated 5/10/2025 documented resident had severe cognitive impairment.The 6/23/2025 nursing note documented the physician ordered transfer to hospital, resident's representative was notified and agreed. The 6/24/2025 physician note documented the resident was sent out to hospital for further evaluation.The 6/24/2025 nursing note documented the resident was admitted to the hospital.2. Resident # 191 was admitted with diagnoses that included major depressive disorder, bipolar disorder, and nicotine dependence. The Minimum Data Set admission assessment of 1/07/2025 documented the resident was cognitively intact. The Minimum Data Set Discharge assessment of 6/9/2025 documented return not anticipated. Resident was discharged to the community.During an interview on 08/13/2025 at 4:13 PM, the Director of Nursing stated nursing was responsible for notifying the family of the bed hold policy. The Director of Nursing reviewed Resident #189's medical record was not able to provide documented evidence that the family was verbally informed of the bed hold policy and that the family was notified of the bed hold policy in writing. The Director of Nursing further stated that the Social Worker was responsible for notifying the Ombudsman office of resident transfers and discharges.During an interview on 08/13/2025 at 4:34 PM, the Director of Social Services stated they were responsible for sending the Transfer/Discharge Notice to the Ombudsman office for all resident transfers and discharges. The ombudsman should have received all transfers and discharge notices, but they were unable to provide documented evidence that the ombudsman was notified of Resident #189 and Resident #191 transfer and discharge. The Director of Social Services stated it was an oversight on their part. 10NYCRR 415.3(i)(1)(iii)(a-c)

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	335806	A. Building B. Wing	08/15/2025

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on observation, record review and interview conducted during the recertification survey 8/11/25 to 8/15/25, the facility did not ensure the accuracy of the Minimum Data Set (resident assessment tool) for one of three residents (Resident #16) reviewed for urinary catheter. Specifically, the Minimum Data Sets with reference dates of 6/22/25 (quarterly), 3/24/25 (annual) and 12/24/24 (quarterly) were coded incorrectly, indicating the resident had an indwelling urinary catheter.Findings include:Resident #16 was admitted with diagnoses including benign prostatic hyperplasia, acute cystitis, and urinary retention. The 3/26/25 Urinary Incontinence Care Plan documented occasional incontinence of bladder function with interventions to monitor for symptoms of urinary tract infection and change in continence status. Resolved from the plan of care was the Foley (urinary) Catheter/Suprapubic care plan.The 4/11/24 physician orders documented to remove the urinary catheter.The 4/12/24 nursing progress note documented the resident's urinary catheter was removed.The 6/22/25, 3/24/25 and12/24/24 Minimum Data Set documented Resident #16 had an indwelling catheter.During an interview on 08/12/25 at 12:04pm, Licensed Practical Nurse #14 stated Resident #16 had not had a urinary catheter for over a year.During an interview on 08/13/2025 at 11:36 AM, Minimum Data Set Coordinator #3 stated it was a mistake on the most recent quarterly assessment (6/22/25). When asked about the annual assessment (3/24/25) and the previous quarterly assessment (12/24/24) they stated they were not sure how it happened since they typically check for accuracy. 10NYCRR 415.11 (b)

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F 0657 Level of Harm - Minimal harm or potential for actual harm 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. Based on observations, interviews, and record reviews conducted during the recertification survey from 8/11/2025 to 8/15/2025, the facility did not ensure that the Comprehensive Care Plan was revised to reflect preventative interventions for 1 of 7 residents (Resident #64) reviewed for accidents. Specifically, Resident #64's Comprehensive Care Plan was not updated to reflect new risk reduction fall interventions implemented after a fall. Findings include:The facility policy Falls Prevention and Management, reviewed 6/2025, documented the interdisciplinary team identifies and implements appropriate interventions to reduce the risk of falls or injuries while maximizing dignity and independence. Determining causal factors leading to a resident fall is necessary to provide consistent intervention to help prevent further occurrences. Adjust/add interventions on the fall plan of care, including date of new intervention. Discuss identified trends and immediately implement appropriate measures to prevent injury. Resident #64 had a diagnosis of Alzheimer's disease, difficulty walking, osteoporosis, and history of falls. The 8/6/2025 Minimum Data Set (a resident assessment tool) documented the resident's cognition was severely impaired. The resident required supervision with transfers from sitting to standing, toileting, and walking; and one fall with injury since the prior assessment. The 8/5/2025 nursing fall/accident progress note documented that Resident #64 had an unwitnessed fall, found lying flat on floor next to the foot end of their bed, unable to state what happened due to cognition. There was swelling to the right side of the resident's forehead, and ice pack was applied to swollen area, and neuro checks completed. The nursing fall risk assessment completed 8/5/2025 documented Resident #64 with a total of 35 for risk of falling (moderate risk).The 8/5/2025 medical progress note documented Resident #64 sustained a fall, ice compression and pain medication given, sent to the emergency room, deferred x-ray, and neuro checks for 24 hours. Medical plan documented in the progress note was to redirect Resident #64 to use the call bell. The 4/10/2025 Falls care plan documented interventions effective 4/10/2025 included to provide reality orientation, floor free from clutter, rehab referral, psychiatry consult, gradual dos antidepressant, anticipate resident's activities of daily living needs, bed in lowest position. New interventions effective 8/5/2025 were a medical work up.During an interview on 08/13/2025 at 12:24 PM, Licensed Practical Nurse #14 stated certified nursing aides made rounds to check on residents when they were in their room. During an interview on 08/14/2025 at 12:10 PM, Unit Manager Registered Nurse #15 stated an intervention to put in place after a fall was more frequent rounding. They stated this did not have to be in the care plan because nursing staff knew to do it. They stated the unit had mostly residents with cognitive deficits and was staffed with 2-3 certified nurse aides on night shift, rounding could be done more frequently. During an interview on 08/15/2025 at 8:35 AM, the Director of Nursing stated an investigation using a root cause analysis to determine the underlying cause of a fall should have been conducted. Standard rounding was hourly but maybe needed to be more frequent. Updated interventions should have been added to the care plan. 10 NYCRR 415.11(c)(2)(i-iii)

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	335806	A. Building B. Wing	08/15/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review during the recertification and abbreviated surveys (2564017 and 781248/NY00353892) from 08/11/2025-08/15/2025, the facility did not ensure that residents who were unable to carry out activities of daily living received the necessary services to maintain good grooming and personal hygiene for two of seven (2 of 7) residents (Resident #199 and Resident #200) reviewed for Activities of Daily Living. Specifically, 1) Resident #199 required assistance with activities of daily living and the certified nurse aide documentation was inconsistent; 2) Resident #200 required assistance with activities of daily living and the certified nurse aide documentation was inconsistent. The facility policy Activities of Daily Living Care Supporting Resident, last reviewed 03/2025, documented residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. Activities of Daily Living documentation will be completed by the Certified Nurse Aide that provided the assistance (and other licensed nursing personnel that provide assistance) by the end of each shift. If an activity was not attempted, it should be documented with a reason. 1)Resident #199 had diagnoses that included, but not limited to, dementia, depression, and anxiety.The Five-Day Minimum Data Set, dated [DATE] documented resident with severely impaired cognition, no behaviors including refusals of care, and required maximal assistance with toileting and dressing.The Quarterly Minimum Data Set, dated [DATE] documented severely impaired cognition, no behaviors including refusals of care, required supervision assist with toileting and dressing.The Functional Abilities Care Plan initiated 06/21/2024 documented resident required moderate assistance for personal hygiene and upper body dressing and maximal assistance for toileting and lower body dressing. The certified nurse aide documentation for 07/2024 documented 135 omissions for certified nurse aide care, toileting, and dressing.The certified nurse aide documentation for 08/2024 documented 70 omissions for certified nurse aide care, toileting, and dressing. During an interview on 08/13/2025 at 12:34PM, Resident #199's family member stated Resident #199 was a resident at the facility and passed away there on 09/23/2024. Resident #199 was often found soiled or wet when the resident's spouse arrived to visit and was not dressed in their own clothing. During an interview on 08/14/2025 at 10:36 AM, Certified Nurse Aide #6 stated activities of daily living documentation was completed each shift. They also sign if there was a refusal, or if the task was not completed with a reason for why it was not performed. There should not be omissions on the record. During an interview on 08/14/2025 at 11:11 AM Registered Nurse Unit Manager #15 stated there should not be any omissions on the certified nurse aide documentation. An omission indicates the care was not rendered. 2)Resident #200 was admitted with diagnoses that included, but not limited to, cancer, renal insufficiency, and diabetes mellitus. The Five-Day Minimum Data Set, dated [DATE] documented moderately impaired cognition, no behaviors including refusals of care, and required maximal assistance for toileting and moderate personal hygiene. The Functional Abilities Care Plan re-initiated 02/26/2025 documented resident required moderate assistance with personal hygiene and maximal assistance with toileting and transfers.A nursing note dated 03/01/2025 documented resident incontinent of bowel and bladder.A medical note dated 03/06/25 documented groin rash complaint, skin assessment no lesions, intact, rash, nystatin order. Nursing notes dated 03/07-03/08/2025 documented malodorous loose stool. Nursing notes dated 03/10-03/12/2025 documented persistent loose stool. The certified nurse aide documentation from 02/27-03/15/2025 documented 35 omissions for certified nurse aide care, toileting, and personal hygiene During an interview on 08/14/2025 at 9:36 AM, Resident #200's family member stated they had personally provided incontinence care for Resident #200 during their stay there. There was a day when another family member called them to report that Resident #200 was covered in feces. They went to the facility to change Resident #200, and the staff were upset that they soiled the sheets in the process. They stated that Resident #200 (continued on next page)

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	08/15/2025

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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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was dying, and they just wanted them clean and comfortable. During an interview on 08/15/2025 at 9:26 AM, Registered Nurse Unit Manager #2 stated that the certified nurse aides document the care provided for the activities of daily living. If a task was not completed, they should document not performed with a reason. There should not be any omissions on the certified nurse aide documentation. If it was not documented, it was not done. During an interview on 08/15/2025 at 10:33 AM, Certified Nurse Aide #7 stated that Resident #200 did need to be provided frequent incontinence care. They signed the activities of daily living for all areas including cares not provided with a reason. There should not be any blanks or omissions because if it was not documented it was not done. 10NYCRR 415.12(a)(3)

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	335806	A. Building B. Wing	08/15/2025

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews conducted during the recertification survey from 08/11/2025 through 08/15/2025, the facility did not ensure that emergency equipment was readily available for one of two residents (Resident #125) reviewed for respiratory care. Specifically, Resident #125, who had a tracheostomy, did not have an Ambu bag (a handheld device that provides positive pressure to residents who are not breathing) at the bedside. Findings include: The facility's policy and procedure titled Tracheostomy Care, last revised in April 2025, documented an emergency tracheostomy setup was to be maintained at the resident's bedside.Resident #125 had diagnoses including chronic respiratory failure with hypoxia, tracheostomy, and dysphagia. The Quarterly Minimum Data Set, dated [DATE], documented the resident had severe cognitive impairment and was dependent on a tracheostomy and oxygen therapy.The comprehensive care plan titled Respiratory Care, dated 08/24/2024, documented maintaining the resident's airway.During an observations on 08/12/2025 at 11:00 AM, 08/13/2025 at 12:00 PM, and 08/14/2025 at 10:00 AM, Resident #125 did not have an Ambu bag at the bedside.During an interview on 08/14/2025 at 10:00 AM, Registered Nurse #9stated there was not an Ambu bag at the bedside and stated they did not know where the nearest one was. They stated the resident's tracheostomy was stable.During an interview on 08/14/2025 at 10:10 AM, Registered Nurse Unit Manager #2 stated there used to be an Ambu bag at the bedside. They stated there was no Ambu bag at the bedside and they were responsible for ensuring that one was available.During an interview with the Director of Nursing on 08/14/2025 at 12:30 PM, the Director of Nursing stated that there should have been an Ambu bag at the bedside and stated the unit manager was responsible for ensuring one was in place. 10 NYCRR 415.12(g)(2).

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	335806	A. Building B. Wing	08/15/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review conducted during the recertification survey from [DATE] to [DATE], revealed that the facility did not ensure that drugs and biologicals were stored according to current professional standards for 2 out of 7 residents (Resident #60 and Resident #115) reviewed for medication storage and labeling. Specifically, 1) Resident #60 was observed three times with Carboxy-methylcellulose 0.5% eye drops, Deep Sea Nasal Spray 0.65%, and a Budesonide-Formoterol 80-4.5 micrograms/actuation metered-dose inhaler on their bedside table. 2) Resident #115's Humalog 100 units/milliliter insulin pen was observed on a medication cart on [DATE]. The insulin pen had an opening date of [DATE], which is past the manufacturer's recommendation to discard it after 28 days after the opening date and was found 17 days after the recommended discard date on the medication cart.The findings include: 1.The 3/2025 facility policy on self-administration of medications states that if a resident expresses a desire to self-medicate or is deemed appropriate for self-administration, an assessment will be completed by a nurse. This assessment will be reviewed by the interdisciplinary team before implementation. The resident's capability for self-administration will be documented either on the Medication Self-Administration Assessment or in the nurse's progress notes. Additionally, physician orders must be obtained for both self-administration of medication and for keeping medication at the bedside. Resident #60 had diagnoses including acute and chronic respiratory failure, hypoxia, depression, and anxiety disorder. The admission Minimum Data Set (an assessment tool) dated 8/11/ 2025, documented the resident had intact cognition and required assistance from one person for activities of daily living, including personal care. A review of Resident # 60 comprehensive care plan did not reveal a care plan for self-administration of medications. The [DATE] physician orders included Symbicort 80 mcg- 4-5 mcg/actuation Hydrofluoroalkane aerosol inhaler, inhale 2 puffs by inhalation route two times per day in the morning and evening. Instruct resident to rinse mouth with water after each use to prevent oral thrush; and Albuterol sulfate 2.5 mg/3ml (0.083%) solution for nebulization, inhale 3 Milliliters (2.5 Milligram) by nebulized route every four hours. The [DATE] physician orders included Refresh Optive 0.5 %-0.9% eye drops, give one drop to both eyes every six hours as needed; and [NAME] Long- Acting 0.05% Nasal Spray, 2 sprays in each nostril by intranasal route two times per day in the morning and evening as needed at 9:00 AM and 5 PM. During observations and interviews on [DATE] at 7:39 AM, [DATE] at 1:07 PM, and [DATE], at 9:46 AM, Resident #60 had Carboxy-methylcellulose 0.5% eye drops, Deep Sea Nasal Spray 0.65%, and a Budesonide-Formoterol 80-4.5 micrograms per actuation metered-dose inhaler on their bedside table. Resident #60 stated they had their medications at their bedside and took them themselves because the nurses did not administer them on time. During an observation and interview on [DATE] at 9:46 AM, Licensed Practical Nurse Unit Manager # (continued on next page)

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	335806	A. Building B. Wing	08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3 stated residents should not have their medications at the bedside without proper assessment. They stated the resident would need clearance from the medical doctor to keep the medication there and it was necessary to ensure the resident had the capacity to administer their medication correctly. During the interview, Licensed Practical Nurse Unit Manager # 3 observed the medications at Resident #60's bedside and stated to the resident that they would discuss the request for having medication at the bedside with the physicians, emphasizing that the medication should not be stored there without a physician's approval. During an interview on [DATE] at 1:43 PM, the Assistant Director of Nursing #1 stated residents should not have any medications at their bedside. They stated that the resident would need to be assessed to determine whether they had the capacity to understand how to take their medications properly, including awareness of the side effects. They also stated that a physician's order would be required for self-administration of medications. 2) The facility Medication Storage Policy, review date 2/2025, Procedure #5 documented the facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed. The Medication Administration/Disposition policy, review date [DATE], Procedure#9 documented the expiration/beyond use date on the medication label must be checked prior to administering. When opening a multi dose container, the date opened shall be recorded on the container. During an observation of the 2 [NAME] medication cart on [DATE] 10:10 AM, with Licensed Practical Nurse #1, an Insulin pen for Resident #115 had an open date of [DATE]. During an interview on [DATE] at 11:50 AM, Nurse Manager #2 stated that it was the responsibility of the nurse administering the medication to check the expiration dates. They stated that the Insulin was last administered yesterday ([DATE]) and the unit manager and the pharmacy consultant that were responsible for auditing the carts. The nurse manager stated that it was an oversight that the expired Insulin pen remained in the cart. During an interview on [DATE] at 12:33 PM, Licensed Practical Nurse #1 stated that it was the responsibility of the Registered Nurse and the Unit Manager to check the expiration dates. Licensed Practical Nurse #1stated that they did not administer the medication on [DATE] as it was administered based on a sliding scale and the resident did not require it on [DATE]. They stated that it was an oversight that the medication remained in the cart and they were aware it needed to be discarded 28 days after opening. 10 NYCRR 415.18(e) (1-4)

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	335806	A. Building B. Wing	08/15/2025

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. Based on observations, record review and interviews conducted during the recertification survey from 8/11/2024 to 8/15/2024, the facility did not ensure that special eating equipment and utensils were provided for residents who need them. This was observed during dining observation for 1 of 6 residents reviewed for nutrition (Resident #17). Specifically, Resident #17 was observed on three occasions eating without the use of the proper assistive devices as indicated in the meal tray ticket, recommended by occupation therapy and ordered by the medical doctor.Findings include:Resident # 17 was admitted with diagnoses that included cerebral infarction, peripheral vascular diseases, and Type 2 diabetes.The Quarterly Minimum Data Set (an assessment tool) dated 08/02/2025 documented the resident had intact cognition, impairment on bilateral upper/lower extremities and required supervision assistance with eating.The Rehabilitation: Contractures Care Plan effective 7/28/2025 documented the resident had a left and right upper extremity contracture which interfere with the ability to use feeding utensils. The interventions documented that therapeutic devices including scoop plate, rocker knife, built up spoon and fork be used. The Functional Abilities: Self Care plan created 07/28/2025 documented the resident required supervision/touching assistance with eating. The interventions documented a scoop plate, rocker knife, built up spoon and fork with all meals.A dietary order renewed 07/14/2025 documented the following adaptive equipment to be used at meals included scoop plate, rocker knife, built-up spoon and fork.An Occupational Therapy Evaluation and Plan of Care created on 7/31/2025 recommended the following therapeutic devices to be used at meals: scoop plate, rocker knife, built up spoon and fork.A medical order dated 8/11/2025 documented the following adaptive equipment with all meals: scoop plate, rocker knife, built up spoon and fork.On 08/12/2025 at 11:38 AM, Resident #17 was observed using a normal plastic spoon to eat cereal in the dining room. During an interview conducted on 08/13/2025 at 10:25 AM, Certified Nurse Aide #16 stated Resident #17 was supposed to have a weighted spoon, but they used a regular spoon. On 08/13/2025 at 12:43 PM, Resident #17's food tray was observed with no rocker knife and instead had a regular knife. The meal tray ticket documented the resident was to receive the built-up spoon, fork and rocker knife.On 08/14/2025 at 12:26 PM, Resident #17's food tray was observed with no rocker knife and instead had a regular knife. The meal tray ticket documented the resident was to receive the built-up spoon, fork and rocker knife.During an interview on 8/14/2025 at 12:28 PM, Resident #17 stated they need the rocker knife during meals since they are unable to cut turkey and other meats.During an interview on 08/14/25 at 09:45 AM, the Director of Rehabilitation stated that Resident #17 was referred by the nursing staff due to a decrease in their ability to assist with activities of daily living. Resident #17 was evaluated on 7/29/2024 and the evaluation recommended physical and occupational therapy services 3 times a week and for a built-up fork and spoon with rocker knife at meals.During an interview on 08/14/2025 at 12:29 PM, the Food Service Director stated they were unaware that Resident #17 did not receive the Rocker Knife with their meal. The Food Service Director stated between 7 and 8 residents receive adaptive equipment and there was sufficient rocker knifes available. The meal ticket stated a rocker knife was required and they would check with the kitchen staff and get the resident the proper knife. 10 NYCRR 415.14 (g)

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	335806	A. Building B. Wing	08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews conducted during the recertification survey from August 11, 2025, through August 15, 2025, the facility did not maintain an infection prevention and control program designed to prevent the development and transmission of communicable diseases and infection. Specifically,1) Licensed Practical Nurse #13, did not don a gown while providing wound care to Resident #165, who was on enhanced barrier precautions; 2) Home Health Aide #4 did not perform proper hand hygiene during meal service and assistance with feeding Resident #183; and 3) Home Health Aide #8 did not perform hand hygiene after feeding Resident #157 and then fed another resident during a breakfast meal. Findings include: 1) The policy and procedure titled Enhanced Barrier Precautions, last revised April 2025, directed staff to maintain enhanced barrier precautions, requiring the use of personal protective equipment, including gowns and gloves, during high-contact resident care activities such as nursing care, dressing changes, and handling medical devices. Resident #165 had diagnoses of dementia, pressure ulcer of the right heel, and peripheral vascular disease. The Quarterly Minimum Data Set, dated [DATE], documented that the resident had severe cognitive impairment and one unhealed venous ulcer. The comprehensive care plan for enhanced barrier precautions, last updated 4/28/2025, directed staff to use gowns and gloves during high-contact resident care activities, to don a gown before beginning care, and to remove the gown before leaving the patient environment. A review of the personal protective equipment competency dated 2/25/2025, revealed Licensed Practical Nurse #13 was deemed competent in using personal protective equipment. The physician’s order dated 7/14/2025, documented to maintain enhanced barrier precautions for the wound on the resident’s right heel. The physician’s order dated 7/16/2025, documented to cleanse the resident’s right heel with Dakins solution, apply collagen particles and calcium alginate to the wound base, and secure the wound with a bordered foam dressing. During an observation on 8/14/2025 at 10:00 AM. Licensed Practical Nurse#13 performed wound care on the resident’s right heel. An enhanced precaution sign was posted on the door, personal protective equipment was readily available, and a red garbage can was outside the bathroom door. At no time during the treatment did the nurse wear a gown. During an interview on 8/14/2025 at 10:15 AM, Licensed Practical Nurse#13 stated they did not wear a gown during the treatment. The nurse acknowledged that they were required to wear a gown because the resident was on enhanced barrier precautions and confirmed that they had previously been educated on the different precautions. During an interview with Registered Nurse Unit Manager#2 confirmed they were responsible for ensuring staff compliance with facility policy. The unit manager stated that all staff had been (continued on next page)

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	335806	A. Building B. Wing	08/15/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	educated on enhanced barrier precautions and acknowledged that Licensed Practical Nurse#13 should have worn a gown during the treatment. 2) During an observation on 08/13/2025 at 12:34 PM, Unit 2 North nursing staff including the registered nurse unit manager, licensed practical nurse, certified nurse aides, and home health aides were serving residents lunch meal without using hand sanitizer, hand sanitizing wipes or hand washing between tray pass and set up among residents. At 12:42 PM Home Health Aide #4 was observed picking up a chair by the arms to move with bare hands, picked up Resident #6's personal bag from the floor with bare right hand, pushed Resident #183's chair to the table and touched the arm rests with bare hands. Home health aide #4 then sat to feed Resident #183 without washing or sanitizing hands. During an interview on 08/13/2025 at 12:55 PM Home Health Aide #4 acknowledged being aware of hand hygiene and removed a small bottle of hand sanitizer from their pocket to show they had sanitizer but shook head no that they did not use it at any time of passing trays or assisting feeding resident #183. During an interview on 08/14/2025 at 9:05 AM, the Assistant Director of Nursing #2 stated they conducted random audits to check that hand hygiene was completed and provided in-servicing to staff at least quarterly. During an interview on 08/14/2025 at 11:47 AM, Licensed Practical Nurse #14 stated most staff feeding training was learned as school curriculum. Assistant Director of Nursing #2 provided education on hand hygiene requirements during meals and the Unit Managers monitored to see it was followed. During an interview on 08/14/2025 at 12:26 PM Registered Nurse Unit Manager #15 stated staff should sanitize hands when passing trays from one table to the next and before assisting a resident with feeding. They monitored staff for hand hygiene during meal service. 3) During an observation on 8/11/25 at 8:45 AM in the 2 East Dining Room, Home Health Aide #8 was feeding Resident #157. They did not perform hand hygiene when finished, then went to another resident’s tray and touched items to give to that resident. (straw and milk container). During an interview on 8/11/2025 at 8:50 AM, Home Health Aide # 8 stated they did not perform hand hygiene after feeding the resident, but they did wash their hands in the sink before feeding the resident. Home Health Aide #8 also stated that they had been trained on infection control. During an interview on 08/14/2025 at 8:54 AM the Assistant Director of Nursing #2 stated that In-servicing was done with all Home Health Aides on proper hand hygiene with a return demonstration. Assistant Director of Nursing #2 stated that hand hygiene audits were done in the mornings using the annual in-service check list. §415.19(b)(4).

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	335806	A. Building B. Wing	08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observations, interviews and record reviews conducted during the Recertification survey on 8/11/2025 to 8/15/2025 the facility did not maintain an effective pest control program so that the facility was free of flies. Specifically, Resident #8's room was observed with several flies.Findings are:The facility policy and procedure titled Pest Control last reviewed 5/2025 documented it is the responsibility of the Maintenance Department to coordinate the control of pests with a company engaged in business of providing Pest Control Services. Pest control Company will provide the control of other insects that may be harmful to humans, equipment, supplies through direct and/or indirect contact or contamination.During an observation on 8/12/2025 at 8:50AM, flies were observed on Resident #8's room.During a subsequent observation on 8/13/2025 at 9:27AM, Resident #8's room was observed with several flies on the pillow, at the bedside chair, on the call bell cord, on the bedside table napkin, on the bed sheets, on the closet door and on the Resident #8's big toe and on the urinal cover. Resident #8 stated that there were flies in their room and they reported it to the staff.During an interview on 8/13/25 at 9:28 AM, LPN #5 stated they had seen the flies in Resident # 8's room. They stated that an exterminator came to the facility but was not sure when they come.During an interview on 8/13/2025 at 9:44AM, Registered Nurse Unit Manager #10 stated they were made aware of the flies in Resident # 8's room early last week, Monday or Tuesday. They further stated they reported the presence of several flies in Resident # 8's room to their entire clinical team specifically to the Director of Housekeeping Department and the Administrator.During an interview on 8/13/2025 at 10:01AM, the Director of Housekeeping stated they were aware of the flies in Resident # 8's room. They stated that the exterminator was in the facility on Monday, 8/11/2025 but was not sure if the exterminator went to Resident # 8's room that day.During an interview won 8/13/2025 at 10:12AM, Maintenance staff # 11 and Maintenance staff #12 both stated they were not aware of the flies in Resident # 8's room or in any other rooms in the building as it was not reported to them. They stated that the Director of Maintenance was not in the building since last week.During an interview on 8/13/2025 at 10:15 AM, with the Administrator and with the Maintenance staff, the Administrator stated that the Pest Control Company was in the facility on Monday, 8/11/2025. The Administrator stated they were not aware that there were flies in resident rooms. The Administrator stated that the Director of Maintenance was responsible for pest control in the building but was not available as they were not in the building last week. The Administrator was not able to provide documented evidence in the Pest Control log of a report for 8/11/2025. They stated that they would get the report from All State Pest Control Company. During the interview, the Administrator provided the Pest Control log. Upon review of the Pest Control log with the Administrator, the log documented dates from 1/27/25 to 7/28/25. The log had no documented evidence that Resident # 8's room or other resident rooms were checked during those dates. The Administrator stated they would contact the Pest Control Company to inspect resident rooms.On 8/13/2025 at 11:29AM, the [NAME] President of Operations provided the Pest Control report dated 8/11/25 that documented Hornet nests in patio and another in the parking lot. The report did not document that Resident #8's room or any other rooms were checked for flies.10 NYCRR 415.29(j)(5)

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	335806	A. Building B. Wing	08/15/2025

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F 0948 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that paid feeding assistants have the training they need. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews during the recertification survey 8/11/25-8/15/25, the facility did not ensure individuals working in the facility under the title Home Health Aides, had successfully completed a State-approved training program for feeding residents for 12 of 12 employees reviewed (Home Health Aides #4, #8, #32, #33, #34, #35, #36, #37, #38, #39, #40 and #41.) Specifically, there was no documentation the Home Health Aides received the required training to feed residents and Home Health Aide # 4 was observed feeding Residents on more than one occasion and Home Health Aide#38 and #36 were observed feeding residents on the Dementia Unit.Findings include:The facility policy titled Home Health Aide Utilization and Scope of Duties dated 9/8/22 documented Home Health Aides are to be utilized within the scope of duties outlined in their job description. Home Health Aides provide non-clinical support services that contribute to the comfort, safety and wellbeing of residents and work under the direct supervision of the Director of Nursing or designation.The undated Home Health Aide Job Description documented Home Health Aides report to the Director of Nursing, and their essential functions do not include providing any care, feeding or assisting with transfers.The facility provided certificates for the Home Health Aides which documented they completed Home Health Aide courses from an outside agency.The facility did not provide any proof the Home Health Aides had the eight hour Feeding Assistant Training approved for assisting residents with eating in a nursing home.In an email on 8/15/25 at 10:06AM from the agency that provides Home Health Aide training they documented their Home Health Aide program does not include the separate 8-hour Feeding Assistant Training approved for assisting residents with eating in a nursing home. This is a distinct course regulated by NYSDOH.Resident #62 had diagnoses which included dementia, hypertension and Alzheimer's disease. The Minimum Data Set assessment dated [DATE] documented the resident had moderate cognitive impairment and needed assistance with meals.The Physician orders dated 6/27/25 documented the resident was prescribed regular diet with thin liquids.Resident #183 had diagnoses which included Alzheimer's disease, psychosis and depression. The Minimum Data Set assessment dated [DATE] documented the resident had severe cognitive impairment and was independent with eating.The physician orders dated 7/18/25 included aspiration (choking) precautions, regular diet with thin liquids.Resident #149 had diagnoses which included hypertension, Type II Diabetes, and dementia. The Minimum Data Set an assessment dated [DATE] documented the resident had severe cognitive impairment and needed assistance with eating meals.During an observation on 8/12 at 12:47PM Home Health Aide # 4 assisted and fed Resident #62 lunch and on 8/14/25 at 8:36 AM assisted and fed Resident #183 their breakfast.During an observation on 8/14/25 at 8:33 AM Home Health Aide #36 assisted and fed Resident #149 breakfast.During an observation on 8/14/25 at 8:39 AM Home Health Aide #38 assisted and fed Resident #62 breakfast.During an interview on 8/14/25 at 8:33 AM Home Health Aide #36 stated their job was to help resident who need to be fed their meals. They spend the afternoons out on appointments with residents.During an interview on 8/14/25 at 8:47 AM Home Health Aide #8 stated they received in services done by the facility about different diets. They stated they did not get a lot of training at their school about feeding residents.During an interview on 8/12/25 at 12:47 PM Registered Nurse Unit Manager #15 stated the Home Health Aides assisted with feeding the residents meals and were trained by the Speech and Language Pathologist.During an interview on 08/13/2025 at 2:55 PM Assistant Director of Nursing #1 stated the Home Health Aides were hired for feeding and transportation. The Home Health Aides fed all types of diets including puree, chopped and modified. They stated they did not know about an eight-hour course, but the Speech and Language Pathologist did competencies with the Aides. During an interview on 8/13/25 at 3:00PM the Speech and Language Pathologist stated they did the training with the Home Health Aides and went over each item in the competency. They stated they did a competency review and were not certified to provide training in (continued on next page)

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	08/15/2025

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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F 0948 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	any State course. When staff were hired, they assumed they had all the credentials needed so when they did the competencies, they were just reinforcing feeding residents.During an interview on 08/14/25 at 12:10 PM the Director of Nursing stated the Home Health Aides were hired to escort residents to appointments but was aware they were feeding residents on the units. They were not aware of the eight-hour training class Home Health Aides needed before they could feed residents. 10 NYCRR 415.13(d)