STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335809	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grove at Valhalla Rehab and Nursing Center	61 Grasslands Road Valhalla, NY 10595

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 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. Based on observations, interviews, and record review conducted during the recertification survey from 09/23/2025 to 09/30/2025, the facility did not ensure the resident's right to a safe, clean, comfortable, and homelike environment. This was evident for one (Resident #14) of three residents reviewed for dementia care. Specifically, an odor of urine was observed in Resident #14's room and coming from their mattress. The findings are: The facility policy titled Cleaning and Disinfection of Environmental Surfaces dated 06/02/2025 documented non-critical environmental surfaces can be decontaminated where they are used. On 09/25/2025 at 11:25 AM, Resident #14's room was observed with a strong odor of stale urine and body odor. The odor appeared strongest near the resident's bare mattress. On 09/26/2025 at 5:20 PM, Resident #14's room was observed with a strong odor of urine without Resident #14 present in the room. On 09/30/2025 at 2:17 PM, the Administrator was interviewed and stated the former Housekeeping Director left a few weeks ago and the Administrator was currently covering. Environmental rounds for cleanliness were performed at least daily by housekeeping staff and/or the Administrator. The Administrator stated the housekeeping staff were responsible for cleaning resident mattresses daily during standard resident room cleaning. Nursing staff were responsible for alerting housekeeping staff if a resident's mattress required cleaning outside of the normal daily room cleaning. Housekeeping replaced mattresses as needed if damaged or particularly soiled. The Administrator stated they were unaware that Resident #14's room had a strong odor of urine. 10 NYCRR 415.5(h)(2)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review conducted during the recertification and abbreviated (#2575165) survey from 09/23/2025 to 09/30/2025, the facility did not ensure the resident's right to be free of abuse. This was evident for two (Resident #8 and #118) of 19 residents reviewed for abuse. Specifically, 1) Resident #8 reported Resident #14 wandered into their room and touched their leg. There was no evidence the facility developed a plan to prevent further potential abuse of Resident #8 by Resident #14; and 2) Resident #14, who had a known history of wandering and resident-to-resident altercations, wandered into Resident #118's room at night. Resident #118 injured their left elbow trying to remove Resident #14 from their room. As a result, Resident #118 reported being fearful and began closing their door at night to prevent Resident #14 from wandering into their room.The findings are: The facility policy titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating dated 09/2024 documented if resident abuse is suspected, it must be reported immediately to the Administrator who is responsible for determining what actions are needed for the protection of residents. The facility policy titled Resident to Resident Abuse dated 11/2024 documented all altercations are investigated and reported to the nursing supervisor, the Director of Nursing, and the Administrator. Facility staff monitor residents for aggressive behavior and wandering into other resident rooms. 1) Resident #8 had diagnoses of congestive heart failure and chronic obstructive pulmonary disease. Minimum Data Set 3.0 assessment dated [DATE] documented Resident #8 had minimal difficulty hearing and was cognitively intact. The Grievance Investigation dated 07/28/2025 documented Resident #8 reported Resident #14 came into Resident #8's room at night and touched Resident #8 while the resident was lying in bed. The facility offered Resident #8 a room change to a unit away from Resident #14. The Comprehensive Care Plan related to abuse risk created 08/28/2025 documented Resident #8 was at risk for abuse related to their dependence on others for assistance with activities of daily living. Interventions to prevent abuse included providing Resident #8 with activities of daily living care as needed, support, social services, and a safe person to receive abuse reports. There was no documented evidence an adequate and individualized care plan was developed and implemented to address the potential for Resident #8 to be abused by Resident #14. On 09/26/2025 at 9:13 AM, Resident #8's family member was interviewed via telephone and stated Resident #8 reported Resident #14 wandered into their room one night at the end of 07/2025 and touched Resident #8's leg while they were lying in bed. The family member stated they reported this to the facility and Resident #8 was offered a room change to a different unit and agreed. Resident #8 did not like their new unit, and their room was changed back to their previous unit with Resident #14, except now Resident #8's room was on the opposite side of the unit from Resident #14. The family member stated they visited Resident #8 after the allegation was reported and observed Resident #14 wandering the unit. The family member stated they did not feel enough was being done by the facility to prevent potential abuse of Resident #8 or other residents by Resident #14. On 09/28/2025 at 5:20 PM, Resident #8 was interviewed and stated they reported an allegation to the facility that Resident #14 entered their room and touched their leg. Resident #8 stated they told Resident #14 to stop touching them and leave their room and Resident #14 complied. Resident #8 stated they agreed to have their room changed at the time of the incident and now resided on the opposite side of the unit from Resident #14. Resident #8 stated there had not been any other incidents involving Resident #14, but they continued to see Resident #14 wandering the halls on Resident #8's side of the unit. 2) Resident #118 had diagnoses of cerebral infarction with left hemiplegia and hemiparesis and interstitial pulmonary disease. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #118 had mild cognitive impairments and did not display any behaviors. The Comprehensive Care Plan related abuse initiated 06/22/2024 and last reviewed 04/25/2025 documented Resident #118 was at risk for being the victim of abuse related to sharing common areas with other cognitively impaired residents. Interventions to prevent abuse included assessing the resident for bruises, investigating all allegations, providing Resident #118 with support, and relocating the aggressor or Resident #118 as needed. The Nursing Note dated 08/24/2025 documented Resident #118 reported Resident #14 came into their room last night and Resident #118 bumped their left elbow trying to get Resident #14 out of their room. No bruising or redness was noted at the time and Resident #118 was instructed to use the call bell next time. The Physician Orders dated 08/24/2025 documented an order for left elbow x-ray for Resident #118's related to pain. The Nurse Practitioner Note dated 08/25/2025 documented Resident #118 was

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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. Based on observations, interviews and record review during the recertification and abbreviated surveys (NY00335938) from 9/23/2025 to 9/30/2025, the facility did not ensure all alleged violations of abuse were reported immediately, but not later than two (2) hours to the state survey agency and the results of an alleged abuse investigation was reported to the state survey agency within five (5) working days of the incident for one (1)(Resident #170) of 20 residents reviewed for abuse. Specifically, on 3/12/2024, Resident #170 alleged their hands were held by a registered nurse during a medication administration. The facility reported the incident to the New York State Department of Health on 3/13/2024 at 5:49 PM and the 5-day investigative conclusion submission was not submitted until 04/25/2024. The findings are:The facility policy titled Abuse Reporting Instructions dated 01/25/2025 documents that the facility notify the appropriate agencies within two (2) hours of an allegation involving abuse and provide a written report of the findings of the investigation within five (5) working days of the occurrence of the incident.Resident #170 had diagnoses of hemiplegia following a stroke, epilepsy, and chronic obstructive pulmonary disease.The Minimum Data Set (an assessment tool) dated 1/12/2024, documented Resident #170 refused to complete the Brief Interview for Mental Status. A Brief Interview for Mental Status completed on 9/02/2025 documented the resident had intact cognition.A Verbal/Physical Staff to Resident Incident Report, dated 3/12/2024 at 9:38 PM, completed by Director of Nursing #2 (no longer at facility), documented staff reported to the Registered Nurse Unit Manager #13 that there was a situation with Resident #170 and Registered Nurse #12 administering medication. Initially it was reported Resident #170 requested their medication then once Registered Nurse #12 entered the room Resident #170 was upset, refused the medication and started hitting Registered Nurse #12 who was blocking the resident's blows. 911 was activated to diffuse the situation and no report was filed. The Registered Nurse Unit Manager #13's written statement dated 3/12/2024 documented the Certified Nurse Aide #2 came running to them and said Registered Nurse #12 attacked Resident #170. When Registered Nurse Unit Manager #13 got to the resident's room, the resident was on the phone with the 911 dispatcher requesting Registered Nurse #12 be arrested. The resident told Registered Nurse Unit Manager #13 they requested their medication multiple times without success and when Registered Nurse #12 came to administer it they refused. Resident #170 stated the Registered Nurse #12 attempted to force the medications into their mouth and the resident began screaming. Registered Nurse #12 stated that they attempted to restrain Resident #170's arms because the resident was hitting them. Registered Nurse Unit Manager #13 notified Director of Nursing #2 and Registered Nurse Supervisor #16 of the incident.The facility reported the incident to the New York State Department of Health on 3/13/2024 at 5:49 PM. Director of Nursing #2 completed the incident report and documented the incident happened on 3/12/2024 at 8:30 PM and administration was notified on 3/12/2024 at 8:40 PM. Review of the 5-day report investigative report documented it was submitted to the New York State Department of Health on 04/25/2024 at 5:53 PM, 43 days after the incident.During an interview on 9/30/2025 at 1:10 PM, Director of Nursing #1 stated their expectation was for the staff to immediately inform a supervisor and then notify the Director of Nursing or Administrator of abuse allegations. The Director of Nursing had two (2) hours to report the incident to the Department of Health. An investigation was to be completed, usually within four (4) days, and then the 5-day report investigation conclusion was sent to the Department of Health. For this incident, the Department of Health was notified on 3/13/2024 at 5:49 PM and the 5-day report investigation conclusion was sent on 4/25/2024 at 5:53 PM. Director of Nursing #1 stated the reports were sent late and they were unable to provide a reason for the lateness since they were not employed by the facility when the incident occurred. 10NYCRR 415.4(b)(1)(ii)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observations, interviews and record review during the recertification and abbreviated survey (NY00335938/647446) from 9/23/2025 to 9/30/2025, the facility did not complete a thorough investigation of an alleged violation of abuse to prevent further potential abuse for one (1) (Resident #170) of 20 residents reviewed for abuse. Specifically, on 3/12/2024, Resident #170 alleged their hands were held by a Registered Nurse #12 during a medication administration and the facility did not complete a thorough investigation resolve inconsistencies and to rule out abuse.The findings are:The facility policy titled Abuse Reporting Instructions dated 01/25/2025 documents that the facility is to review all events leading up to the alleged incident and document the investigation completely and thoroughly. The facility policy titled Abuse Reporting Investigation dated 01/25/2025 documents that all reports of resident abuse (including injuries of unknown origin) are to thoroughly be investigated by facility management. The individual conducting the investigation as a minimum is to review documentation and evidence, review residents medical record, observe the alleged victim, interview the person(s) reporting the incident, interview any witnesses to the incident, interview the resident, interview the resident's attending physician, interview staff members (on all shifts) who had contact with the resident during the incident period, review all events leading up to the alleged incident, document the investigation completely and thoroughly and then at the conclusion, record the findings of the investigation to the administrator. Resident #170 had diagnoses of hemiplegia following a stroke, epilepsy, and chronic obstructive pulmonary disease.The Minimum Data Set (an assessment tool) dated 1/12/2024, documented Resident #170 refused to complete the Brief Interview for Mental Status. A Brief Interview for Mental Status completed on 9/02/2025 documented the resident had intact cognition.Review of the facility's verbal/physical staff to resident incident report dated 3/12/2024 at 9:38 PM, completed by the Director of Nursing #2 (not in the facility at the time of incident and no longer working at the facility), documented on 3/12/2024, staff reported to Nurse Manager #13 a situation with Resident #170 and the nurse administering medication (Registered Nurse #12). Initially it was reported that Resident #170 requested to have their medications and once Registered Nurse #12 entered the room Resident #170 was upset, refused the medication and started hitting the nurse who was blocking Resident #170's blows. 911 was activated to diffuse the situation and no report was filed. No injuries were observed on Resident #170 after the incident. (The report did not include who assessed the resident for injuries at the time of incident.)In Registered Nurse #12's written statement and a progress note dated 03/12/2024 at 9:08 PM, they documented that Resident #170 took keys, narcotics and medications from them, started yelling, hit them multiple times and threw objects into their eyes and around their mouth. Registered Nurse #12 tried to stop the resident from hitting them and called for Certified Nurse Aide #2 to call for security. Registered Nurse #12 left the room to call security themselves. Unit Manger #13 was aware. In a 03/12/2024 statement, Certified Nurse Aide #2 documented they heard yelling and screaming from the resident's room. Resident #170 was saying that their medications were late and to get out of their room. Resident #170 was hitting Registered Nurse #12 and telling them to get out so Registered Nurse #12 held the resident's hands down trying to stop from being hit. Certified Nurse Aide #2 reported the incident to Unit Manager #13.In a 3/12/2024 statement, Unit Manager #13 documented they were alerted to the incident when Certified Nurse Aide #2 came running to them and stated that Registered Nurse #12 attacked Resident #170. Unit Manager #13 went to Resident #170's room and Resident #170 was on the phone with the 911 dispatcher requesting Registered Nurse #12 be arrested. According to Resident #170, they had requested their medications multiple times from Registered Nurse #12 without success. When Registered Nurse #12 came to administer the medications, Resident #170 felt frustrated and refused the medications. Resident #170 stated that Registered Nurse #12 tried to force the medications into their mouth and started screaming get away from me! Unit Manager #13 documented this was confirmed by Certified Nurse Aide #2. Registered Nurse #12 stated they attempted to restrain Resident #170 arms because they were hitting them. Unit Manager #13 informed Registered Nurse #12 it was never appropriate to restrain a resident and force medications into their mouth when they refused. Unit Manager #13 notified the Director of Nursing and Registered Nurse Supervisor #15 of the incident.There was no documented evidence Registered Nurse Unit Manager #13 assessed the resident or wrote a progress note or started and accident/incident report after the incident.A Nurse Practitioner progress note dated 3/13/2024 at 4:15 PM, documented the resident was seen as requested by nursing for evaluation and had a superficial abrasion to the right wrist/hand.The facility's report submitted to the New York State Department of Health

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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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review conducted during the recertification and abbreviated (#2575165) surveys from 09/23/2025 to 09/30/2025, the facility did not ensure a resident diagnosed with dementia, received treatment and services to maintain their highest practicable well-being. This was evident one (Resident #14) of three residents reviewed for dementia care. Specifically, Resident #14 presented with adjustment difficulties after their room was changed to address their dementia behaviors; and a recommended follow-up neurology consult was not scheduled for Resident #14 following a hospitalization due to a change in their mental status. The findings are: The facility policy titled Dementia Care dated 01/06/2025 documented the physician and staff will identify to the extent possible the neurological basis of the resident's dementia. The interdisciplinary team will identify a resident-centered care plan to maximize quality of life. Resident #14 had diagnoses of cerebral ischemia (reduced or blocked blood flow to the brain), dementia without behavioral disturbance, and psychosis. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #14 was severely cognitively impaired and did not display any behaviors. Nursing Notes dated 07/07/2025 through 07/11/2025 documented Resident #14 exhibited wandering daily and regularly entered other resident rooms. The Grievance Investigation dated 07/13/2025 documented Resident #14 had been wandering into Resident #169's room across the hall. The investigation concluded Resident #14 was initially invited to spend time with Resident #169 and their family causing Resident #14 to become familiar with their presence and to visit the resident often. An email attachment documented Resident #14 had to be physically removed from Resident #169's room multiple times, staff were aware of the resident's wandering behavior, and Resident #14 had to be removed from other resident rooms as well. Resident #14 was also observed in Resident #169's room pressing the buttons on the resident's air mattress causing the device to malfunction. The attachment documented Resident #14 had become dangerous to Resident #169. Actions taken to address the concern included moving Resident #14 to a private room down at the end of the hallway. The Nursing Note dated 07/16/2025 documented Resident #14 was adjusting poorly to their new room. The Psychiatry Consult dated 08/02/2025 documented Resident #14 displayed paranoia, continued to wander into other resident rooms, and slept poorly. The Nursing Note dated 08/18/2025 documented Resident #14 had three falls at night and was discharged to the hospital due to altered mental status. The Hospital Discharge Instructions dated 08/21/2025 documented Resident #14 should follow up with neurology for dementia management within one to two weeks. There was no documented evidence a follow-up neurology consult was ordered or scheduled for Resident #14 following their hospitalization for a change in mental status. The Nursing Note dated 08/22/2025 documented Resident #14 was readmitted to the facility following a hospital admission and was alert with baseline confusion. The Comprehensive Care Plan related to impaired cognitive function created 08/23/2025 documented interventions to address Resident #14's long- and short-term memory loss included providing the resident a home-like environment with familiar objects, visible clocks, and consistent care routines. The Recreation assessment dated [DATE] documented Resident #14 found it very important to listen to music they liked. The Recreation assessment dated [DATE] documented Resident #14 would be provided with the music they enjoyed. There was no documented evidence the interdisciplinary team developed and implemented person-centered interventions, including personalizing the resident's living space, to address Resident #14's cognitive impairments and dementia diagnosis. On 09/25/2025 at 8:21AM, Resident #14 was observed in their room sitting at the edge of their bed. At 11:25 AM, Resident #14 was no longer observed in their room and the room .was bare besides the bed and lacked the standard bedside dresser and chairs observed in other resident rooms. There were no personal identifiable effects observed throughout the room and no decorations on the walls. At 1:26 PM, Resident #14 was observed in the floor dining room sleeping in their wheelchair and a tactile stimulation board was observed behind the nursing station. On 09/26/2025 at 5:40 PM, Resident #14 was observed sitting in their wheelchair in their old room, dressed in another resident's long-sleeved shirt. On 09/28/2025 at 4:58 PM, Resident #14 was observed wheeling down their unit hallway. A Certified Nurse Aide approached Resident #14 and said out loud that Resident #14 was not wearing their own shirt and had dressed themselves in clothing from another resident. On 09/28/2025 at 6:11 PM, Resident #14 was observed picking up a plastic container of disinfectant wipes. Resident #14 handled wipes ready to be pulled from the top of the container and set the container back onto the nursing station without

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review conducted during the recertification and abbreviated survey (#2575165) from 09/23/2025 to 09/30/2025, the facility did not ensure a resident's right to be free from unnecessary drugs. This was evident for one (Resident #14) of three residents reviewed for dementia care. Specifically, Resident #14 was ordered to receive Haldol 2 milligrams without a labeled indication and without consideration of recommendations by Psychiatry to decrease the dosage.The findings are: The facility policy titled Psychotropic Medication Use dated 08/02/2025 documented residents who have not used psychotropic medications are not prescribed or given these medications unless necessary to treat a specific condition that is diagnosed and the is based on a comprehensive resident review that evaluates underlying causes. Resident #14 had diagnoses of cerebral ischemia (reduced or blocked blood flow to the brain), dementia without behavioral disturbance, and psychosis. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #14 was severely cognitively impaired, did not display any behaviors, and received antidepressant and antipsychotic medication. The Nursing Progress Notes and Fall Risk Evaluation dated 08/18/2025 documented Resident #14 had three falls at night and was discharged to the hospital due to altered mental status. The Hospital Patient Review Instrument dated 08/21/2025 documented Resident #14 had acute delirium superimposed on dementia. The Hospital Discharge Instructions dated 08/21/2025 documented Resident #14 should have donepezil 5milligrams at night reinitiated, Remeron 30milligrams at daily at bedtime, Haldol 2 milligrams every six hours as needed for agitation, and follow up with neurology within one to two weeks for dementia management. The Nurse Practitioner Telehealth Note dated 08/22/2025 documented Resident #14 was readmitted to the facility on and would continue Aricept, Haldol, and Remeron. The Physician Orders dated 08/23/2025 documented Resident #14 was ordered Haldol 2 milligrams every six hours as needed for seven days for psychosis. The Medication Administration Record dated 08/23/2025 to 08/25/2025 documented Haldol 2 milligrams as needed was not administered to Resident #14. The Nursing Note dated 08/25/2025 documented Resident #14 had behavioral disturbances, refused shower, and got agitated when staff attempted hygiene care. The Medical Doctor gave a verbal order to change the frequency of Resident #14's Haldol 2 milligrams from as needed to every six hours. The Physician Orders dated 08/25/2025 documented Resident #14's order for Haldol 2 milligrams as needed was discontinued and a new order was placed for Resident #14 to receive Haldol 2 milligrams every 6 hours, administered at 6 AM, 12 PM, 6 PM, and 12 AM. The Pharmacist Drug Regimen Review dated 08/25/2025 documented Resident #14 was ordered Haldol for an Off-label, non-Food and Drug Administration-labeled, indication. A Risk-Benefit Assessment was recommended as Haldol Off-label could potentially be an unnecessary medication. The Nurse Practitioner Note dated 08/26/2025 documented Resident #14 would continue Haldol 2 milligrams every six hours for agitation and would follow up with Psychiatry. The Psychiatry Consult dated 09/13/2025 documented a recommendation to decrease Resident #14's Haldol from 2 milligrams to 1 milligrams every six hours. The Nurse Practitioner Note dated 09/14/2024 documented Resident #14 was evaluated following a fall and received Haldol 2 milligrams every six hours. There was no documented evidence the Physician reviewed and documented a response to the Psychiatrist's recommendations to reduce Resident #14's Haldol on 09/13/2025. There was no documented evidence care plan interventions were developed and implemented to address risks and side effects of Resident #14's Haldol use. On 09/26/2025 at 5:40 PM, Resident #14 was observed confused and incoherent in another resident's room, dressed in another resident's clothing. On 09/25/2025 a 1:26 PM, Resident #14 was observed sleeping in their wheelchair in the floor dining room. On 09/29/2025 at 11:58 AM, the Psychiatrist was interviewed and stated Resident #14 was readmitted with an order for Haldol 2 milligrams every 6 hours as needed. The Psychiatrist stated they evaluated Resident #14 and most recently recommended lowering the resident's Haldol order from 2 milligrams to 1 milligrams every six hours. The Psychiatrist stated they received reports from nursing staff that Resident #14's wandering behavior had decreased and determined Resident #14 no longer displayed irritability or paranoid ideation. The Psychiatrist stated they verbally communicated directly with Resident #14's primary Physician, the facility's Medical Director, regarding the recommendation to decrease the resident's Haldol. On 09/29/2025 at 1:12 PM, the Medical Director, Resident #14's primary care physician, was interviewed via telephone and stated they did not question the Psychiatrist's recommendations, whether to start a new or reduce an existing one and ordered whatever the