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

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observations, interviews, and record reviews during the recertification survey from 09/23/2025-09/30/2025, the facility did not ensure that there was sufficient nursing staff to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial wellbeing of each resident. Specifically, the minimum staffing levels did not meet the needs of the residents and residents, family, and staff expressed concerns about low staffing and delays in receiving care.Findings include:The Facility Assessment tool dated 8/5/25 documented there were 160 beds total in the facility and 4 units where residents reside. The minimum staffing levels for Direct Care Staff were documented as for:- the7:00 AM - 3:00 PM shift, one (1) Registered or Licensed Practical Nurse and 3 Certified Nurse Aides on each of the 4 units (for a total minimum of 12 Certified Nurse Aides for 160 residents). - the 3:00 PM to 11:00 PM shift, one (1) Registered or Licensed Practical Nurse and three (3) Certified Nurse Aides for the 1 North and 1 South units, and two (2) Certified Nurse Aides for the 2 North and 2 South units.- the 11:00 PM to 7:00 AM shift, one (1) Registered or Licensed Practical Nurse and one (1) Certified Nurse Aide for each unit.The Facility Assessment tool also documented of the 160 residents: 34 residents had Behavioral Health Needs, 29 residents had Dementia, and 34 residents had depression. The Assessment documented residents who needed assistance of one to two staff for Activities of Daily Living included 114 residents for dressing, 126 residents for bathing, 115 residents for transferring and 137 residents for eating. Of the 160 residents there were 41 dependent (staff does all the work) residents for dressing, 29 residents were for bathing, 39 residents for transfer, 17 residents for eating and 38 residents for toileting. The assessment also documented 43 residents required a mechanical lift for transfer (always need at least 2 staff). The Staffing policy created 03/2022 and last revised in 06/2024 documented its purpose is to provide adequate staffing to meet needed care and services for resident population. Licensed registered nursing and licensed nursing staff are available to provide and monitor the delivery of resident care services and Certified Nursing Assistants are available on each shift to provide the needed care and services of each resident as outlined on the resident's Comprehensive Care Plan. During the Resident Council meeting on 09/24/2025 at 11:01 AM with seven residents in attendance, the residents stated they had to wait a very longtime when they were short staffed. The stated when there were only three Certified Nurse Aides, the wait times increased.During an interview with Resident #114 on 09/24/2025 at 11:05 AM they stated getting a shower was inconsistent and did not happen twice a week as planned. They stated staff would tell them there was not enough staff to give showers. During an interview on 09/24/2025 at 11:56 AM, Certified Nurse Aide #1 stated they were working with three other Certified Nurse Aides that day and had ten residents on their assignment. The facility did not always schedule for four Certified Nurse Aides and when there was only three (3) scheduled it was overwhelming as they had a lot of residents that required assistance with two staff. Certified Nurse Aide #1 stated when there were only three Certified Nurse Aides it was impossible to do the showers. During an interview on 09/26/2025 at 1:12 PM, Resident #141's family member stated that staffing was bad and on weekends, there were two Certified Nurse Aides for 40 residents on the day shift. Sometimes there (continued on next page)

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

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	was only one Licensed Practical Nurse and one Certified Nurse Aide on the day and evening shifts. They had made many complaints over time and no one responded to their requests. They reported to the Nurse Practitioner and Director of Nursing that staff had been rude and did not feel like they were taken seriously. They also stated agency staff were not invested in the residents at all. During an interview on 09/29/2025 at 10:34 AM the Director of Human Resources/Staffing Coordinator stated they started at the end of July in their position and staffing was planned a month in advance. They stated on weekends the Registered Nurse Supervisors work 12-hour shifts from 8 AM to 8 PM and 8 PM to 8 AM then verified Registered Nurse Supervisors identified on the staffing sheets worked the 12 hours shift. They also stated when the Registered Nurse supervisor was not able to work, the Director of Nursing would work or would find Registered Nurse coverage. During an interview on 09/29/2025 at 11:17 AM, the Director of Nursing stated the Director of Human Resources was responsible for staffing and when there was an emergency, the Certified Nurse Aide had to go home, or there were call outs during the night shift that could not be replaced, the nurse would help the Certified Nurse Aide. During an interview on 09/29/2025 at 1:47 PM the 2 North Licensed Practical Nurse #6 stated the acuity level on unit was way too much for one Licensed Practical Nurse to handle alone on the day shift. There were many residents that required two person assist and on occasion they helped the Certified Nurse Aides on the day shift. There were a lot of involved family members and residents that required a lot of time and attention. They stated that it is too much for one Licensed Practical Nurse to handle on their own. During an interview on 09/29/2025 at 3:21 PM, Certified Nurse Aide #23 stated they worked regularly on the day shift on Unit 1 South. They stated staffing was terrible; they used to have five (5) Certified Nurse Aide on the day shift and then the facility cut back. They stated when there was a call out, then only three (3) Certified Nurse Aides covered the unit. When there were three (3) Certified Nurse Aides it was not possible to give showers and they had to give a bed bath, this happened once or twice a week.During an interview on 09/29/2025 at 4:07 PM, Licensed Practical Nurse # 6 stated the staffing situation is very bad. Stated it is very intense and involved on the unit. Involved families are demanding. The challenge is when there are only three Certified Nurse Aides and when that happens it is too difficult. Showers and cares fall by the wayside. Has 16 residents that require Hoyer lift on the unit Each resident needs two staff or Certified Nurse Aide to transfers and two for cares. Sometimes there is just one (1) nurse. The nurse will give medications, pass food, do all wound treatments. Stated they help out as much as possible. Facility blames it on the call outs. Most of call outs of Certified Nurse Aides is due to short staffing. Staff are overworked then staff call out sick. Licensed Practical Nurse # 6 stated the Facility was not doing anything to help with staffing. 10 NYCRR 415.13(a)(1)(i-iii)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews conducted during the recertification survey from 09/23/2025 to 09/30/2025, the facility did not ensure proper storage, preparation, distribution, and service of food in accordance with professional standards for food safety. Specifically, 1) the daily refrigerator/freezer logs had missing temperature, 2) the kitchen refrigerators and spice/seasoning areas contained food items that were expired or were not documented with date opened, use by date or expiration dates, 3) the Unit resident refrigerators contained food products that were not labelled with resident name, bought into facility date and dispose by date, and 4) the dry storage pantry contained food products that did not contain date opened or expiration dates. The findings included: The facility policy titled Food Storage dated 10/2024, documented: All stock must be rotated with each new order received. Good should be dated as it is placed on the shelves. Date marking to indicate the date or day by which a ready to eat, potential hazardous food should be consumed, sold or discarded will be visitable on all high-risk food. Thermometers should be checked at least time times each day. All foods should be covered, labeled and dated. All foods will be checked to assure that foods (including leftovers) will be consumed by their safe use by dates, or frozen (where applicable) or discarded. The facility policy titled Pantry Policy, dated 01/25/2025, documented: The food and nutrition department will check the pantry refrigerators for outdated food items. The refrigerators will be inspected daily. Outdated items will be disposed of. 1) During an observation of refrigerator/freezer temperature logs on 09/23/2025 at 9:31 AM, the following dates were missing temperature documentation: -Refrigerator #1 (dairy) did not have temperatures logged on 09/05/2025 morning or evening. On 09/19/2025, there was no temperature documented for evening.-Refrigerator #3 (produce) did not have a temperature documented on 09/10/2025 for evening. -Refrigerator #4 (meat) did not have a temperature documented on 09/09/2025 morning or evening.-Tray line refrigerator did not have a temperature documented on 09/19/2025 evening.2) During on observation on 09/23/2025 at 9:33 AM of freezer #2, a tray of baked ziti was observed labelled cooked 08/03/2025 and use by 08/09/2025. A tray of Salsbury steak was labelled 08/03/2025 and use by 08/06/2025. During an observation on 09/23/2025 at 9:42 AM of Refrigerator #1 (dairy), the following was observed:- One (1), five (5) pound bag of cheddar cheese was not dated when opened and did not have a use by date. There was approximately three-fourths of bag remaining. -One (1), five (5) bag of shredded mozzarella cheese was labelled opened 09/14/2025 and use by date 09/17/2025. There was approximately one-fourth of bag remaining. -A one pound bar of [NAME] Farm butter was not labeled when opened and had an expiration date of 08/16/2025. There was approximately one-fourth of bar remaining. -A (one) 1 gallon container of Authentic Farms [NAME] barbeque sauce was not labeled when opened and did not contain an expiration date on container. There was approximately one-fourth of container remaining. -One (1) box of 200, 3.5-gram individual packets of Roseli Parmesan cheese packets were not labelled when opened and did not have an expiration date on box or on individual packets. During an observation on 09/23/2025 at 9:57 AM of Refrigerator #4, a 30-dozen box of eggs was observed without a date opened or expiration date label. There were approximately 20 dozen eggs remaining in the box. The box had a supplier label documenting eggs were delivered on 09/08/2025. During an observation on 09/23/2025 at 10:26 AM of the spices/seasonings area, the following was observed:- 16-ounce jars of Yorkville Company Ground Ginger, Monarch Ground Cumin, Ground Thyme leaves and Monarch Whole Basil Leaves were not dated when opened and did not have an expiration date on container. -A 12-ounce container of Premium Label Parsley Flakes was not dated when opened and did not have an expiration date on container. -A six (6) pound container of B'gan Granulated Garlic and a five (5) pound of R&S Ground Cinnamon was not dated when opened and did not have an expiration date on container. 3) During an (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	observation and interview on 09/23/2025 at 12:11 PM with the Unit 1 (one) South Manager, two boxes of Good Humor Creamsicles were observed in the Resident refrigerator freezer, not labelled with resident name, date when bought in to the facility and discard by date. The Assistant Director of Nursing/Unit 1 (one) South Manager stated dietary/kitchen staff observe Unit Pantry Refrigerators daily and remove expired food products. They stated unit nursing staff assist residents/resident representatives with labelling and dating food products bought into to the facility. They stated the Good Humor Creamsicle boxes should have been labelled with resident name, dated when bought in to the facility and dispose by date.During an observation and interview on 09/23/2025 at 12:15 PM of the Unit Two (2) North Unit resident refrigerator, Certified Nurse Aide #1 observed two (2) Jamaican juice drink containers, and two (2) Snapple Iced Tea bottles in a grey bag in resident refrigerator. They stated the bag was not labeled with resident name and did not contain a date bought into facility or discard by date. They stated all food products bought in to facility by family should be labeled with resident name, date bought into facility and a dispose of by date. 4) During an observation of the Kitchen Dry Storage room on 09/23/2025 at 2:34 PM, the following was observed: -A two (2) pound box of dry orzo was not labelled when opened and was labeled with a use by date of 09/10/2025. -A one (1) pound box of Red Mill couscous was not labelled when opened and did not have a use by date. There was no expiration date on box. There was approximately one-half pound remaining in box. -A one (1) pound bag of dry fettucine was not dated when opened and did not have an expiration date.-A ten (10) pound bag of dry spaghetti was not dated when opened and did not haven an expiration date. There was approximately two (2) pounds of spaghetti remaining in bag. During an interview on 09/24/2025 at 10:00 AM the Director of Food Service stated they review temperature checks logs for refrigerator/freezer daily. Cooks are responsible for documenting refrigerator temperatures daily in the morning and evening. They stated when they observe a missing temperature, staff are reminded of importance of logging temperature and re-trained as needed. They stated all kitchen staff receive monthly and as needed in-services on food safety training. The Director of Food Services stated all outside food bought in to the facility should be dated with resident name, date of entry, and use by date (usually 2-3 days after entering facility). They stated the labelling is completed by unit staff or family. They stated kitchen staff observe the unit pantries/resident refrigerators daily and dispose of expired food products/unlabeled items. The Director of Food Services stated Unit staff are expected to label foods bought into the facility by resident/resident family representative and that this is discussed with unit managers during morning meetings to remind unit staff to label food. The Director of Food Services stated all food products in the kitchen refrigerators/freezer and storages areas should be labelled when opened and contain an expiration/use by date. They stated all kitchen staff receive monthly and as needed in-services on food safety training. 10NYCRR 415.14(h)

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F 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident has the right to receive notices in a format and a language he or she understands. Based on observations, interviews, and record review conducted during the rectification survey from 09/23/2025 to 09/30/2025, the facility did not ensure residents received contact information for the New York State Department of Health in a format and language they could understand for seven residents (Resident #42, #48, #49, #54, #96, #118, and #173) at the Resident Council meeting. Specifically, the New York State Department of Health contact information was not posted in a format understood by the Resident Council members.The findings are: On 09/24/2025 at 11:15 AM, Residents #42, #48, #49, #54, #96, #118, and #173 attended the Resident Council meeting and unanimously reported they did not know the contact information for the New York State Department of Health Complaint Intake Unit. At 12:00 PM, after conclusion of the council meeting, observations were made of resident common areas on each unit and in the facility front lobby and the New York State Department of Health Complaint Intake Unit contact information was not observed posted in a way accessible and legible to residents. On 09/25/2025 at 3:44PM, the Director of Social Work stated they were responsible for ensuring the required contact information for the New York State Department of Health was posted on resident units. Posters with the required contact information were put up throughout the facility approximately one year ago. After observing the 2 North and 2 South Units, the Director of Social Work stated they did not observe New York State Department of Health contact information posted in a form legible to residents because the only posting present on 2 North was located in an alcove behind large food trucks and was printed so small, residents at wheelchair height in the unit common areas would not be able to read it. 10 NYCRR 415.3(d)(2)(i)(b)

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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. **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 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 evaluated for left elbow pain, redness, swelling, and trauma. Resident #118 continued to have redness at the site and would be monitored by nursing for pain. An x-ray was negative for acute fracture or changes. The Nurse Practitioner Note dated 08/29/2025 documented Resident #118 continued to exhibit left pain swelling and redness with a pain level of two out of 10. 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] and 08/25/2025 documented Resident #14 was severely cognitively impaired and did not display any behaviors, including wandering. Nursing Notes dated 07/07/2025 through 07/11/2025 documented Resident #14 exhibited wandering daily and regularly entered other resident rooms. The Nursing Note dated 08/24/2025 documented Resident #14 continued to wander on the unit entering other resident rooms. Constant redirection needed. Resident #118 reported they bumped their elbow trying to remove Resident #14 from their room after Resident #14 wandered in. The Comprehensive Care Plan related to behavior created on 08/25/2025 documented Resident #14 was uncooperative, wandered, and received Remeron and Haldol to lessen their behaviors. Other documented interventions included assisting Resident #14 to their room, offering food, and offering toileting. There was no documented evidence adequate interventions were developed and implemented to address Resident #118's risk for being the victim of abuse and Resident #14's risk for abuse related to wandering. On 09/26/2025 at 1:08 PM, Resident #118 was interviewed and stated they recalled the incident of Resident #14 wandering into their room a few weeks ago at night. Resident #118 tried to maneuver Resident #14's wheelchair to redirect them out of the room and injured their left elbow in the process by getting it caught between Resident #14's wheelchair and the doorframe. Resident #118 stated they were in pain and screamed for help, but no staff member came. The incident was reported to the nursing staff in the morning and Resident #118's left elbow was evaluated. Resident #118 stated Resident #14 wandered into their room often at night and they were fearful of Resident #14's unpredictable behavior. Resident #118 stated they did not like keeping their door shut but, after the incident, they began closing their door at night because it allowed Resident #118 to hear and prepare for Resident #14 opening the door at night. Resident #118 stated facility staff had not met with them to discuss a plan to prevent Resident #14 from wandering into their room or to keep Resident #118 safe. On 09/26/2025 at 5:40 PM, Resident #14 was observed in another resident's room, confused, incoherent, and dressed in another resident's clothing. On 09/28/2025 at 6:15 PM, Certified Nurse Aide #20 was interviewed and stated they were assigned to Resident #14 who wandered on the unit regularly, was confused, displayed signs of dementia, and had been progressively declining over the last year. Resident #14 was known to wander into other resident rooms, especially the room they previously resided in. Resident #14 was transferred to their current room at the end of the hallway due to their behavior. Certified Nurse Aide #20 stated interventions to address Resident #14's wandering included every staff member being on alert to monitor Resident #14 if they saw the resident. Resident #14 used to have one-to-one staff supervision when their wandering behavior increased but it was discontinued. Certified Nurse Aide #20 stated they were able to easily redirect Resident #14 when working the night shift and stated that was the main intervention for addressing Resident #14's behavior. On 09/29/2025 at 1:47 PM, Licensed Practical Nurse #15 was interviewed and stated they were the day shift charge nurse on and were (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	familiar with Resident #14's dementia diagnosis and wandering behavior. At one point, 30-minute monitoring of Resident #14 was ordered, but this was discontinued and was no longer in place. Licensed Practical Nurse #15 stated there was no other supervision or monitoring in place to address Resident #14's wandering into other resident rooms. The interdisciplinary team attempted to address Resietn #14's wandering behavior by changing Resident #14's room to one further down the hall. This did not deter Resident #14 from wandering and Resident #14 continued to wander into other resident rooms. Licensed Practical Nurse #15 stated Resident #14's wandering behavior was disruptive to other residents on the unit. Licensed Practical Nurse #15 state Resident #14 had a long history of aggression towards and altercations with other residents. Licensed Practical Nurse #15 stated they were unaware of Resident #8's allegation that Resident #14 wandered into their room and touched their leg. On 09/30/2025 at 10:06 AM, the Assistant Director of Nursing was interviewed and stated staff managed Resident #14's wandering behaviors by involving the resident in activities, performing visual rounding, engaging the resident in conversation, and providing tactile stimulation for Resident #14 to work with something with their hands. The Assistant Director of Nursing stated they did not know Resident #14's former job but Resident #14 usually woke up between 4 AM and 5 AM many mornings thinking they had to go to work and would begin wandering the unit looking for their job. The incident involving Resident #8 was investigated as a grievance instead of an abuse allegation because there was no definitive evidence Resident #8 was touched by Resident #14. The interdisciplinary team offered Resident #8 a room change to a different unit to prevent Resident #14 from wandering into Resident #8's room. Resident #8 agreed to the room change. The Assistant Director of Nursing stated they communicated with the other residents on the unit and were able to appreciate their discomfort and tension in relation to past incidents involving Resident #14 wandering into other resident rooms. The Assistant Director of Nursing was unable to state what interventions were implemented to prevent Resident #14 from entering Resident #118's room again and stated they understood other residents were concerned with the potential for Resident #14 to wander into their rooms or become aggressive towards them again. On 09/30/2025 at 1:12 PM, the Medical Director, Resident #14's primary care physician, was interviewed via telephone and stated Resident #14 began wandering into other resident rooms and became increasingly psychotic and appeared unkempt. The Medical Director stated the facility nursing staff were responsible for investigating any incidents involving Resident #14 and providing the resident with redirection to address their wandering behavior. On 09/30/2025 at 1:43 PM, the Director of Nursing was interviewed and stated Resident #14's wandering behavior could be easily redirected by staff. The Director of Nursing stated they did not believe Resident #14 was a danger to other residents otherwise Resident #14 would be on one-to-one supervision. The facility attempted to use stop signs on resident rooms at one point but found them to be ineffective at stopping Resident #14 from entering other resident rooms. The Director of Nursing stated they were unaware of an incident involving Resident #14 wandering into Resident #118's room. Resident #8's allegation was investigated as a grievance because there was no evidence Resident #14 touched Resident #8. Staff provided Resident #14 with recreational activities and redirection to address Resident #14's wandering behavior. On 09/30/2025 at 2:17PM, the Administrator was interviewed and stated they were aware that Resident #14 had a behavior of wandering but was unaware that this was a problem at night or early in the morning. The Administrator stated they were responsible for reviewing the grievance and accident/incident investigations and signing off on the investigation conclusions determined by the investigating department head. The Administrator stated Resident #14 was easily redirectable and did not have bad intentions.10 NYCRR 415.4(b)(1)(i)

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

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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. 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)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 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. 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 (continued on next page)

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	335809	A. Building B. Wing	11/20/2025

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, by the Director of Nursing #2 on 3/13/2024 at 5:49 PM documented on 3/12/2024 staff reported to Registered Nurse Unit Manager #13 that there was a situation with the patient and nurse administering medication. While Registered Nurse #12 was attempting to administer medications, Resident #170 became upset, yelled at and started to hit Registered Nurse #12 who was blocking the blows. 911 was activated to diffuse the situation and no report was filed. Resident #170 alleged Registered Nurse #12 held their hands. On 3/13/2024, a head-to-toe assessment was completed a Registered Nurse and Nurse Practitioner, and a two-to-three-centimeter scratch was discovered on Resident #170 right wrist. The report documented the nurse was removed from duty pending investigation immediately and several versions of the story were rendered. A review of the 5-day report investigative conclusion submitted to the New York State Department of Health on 04/25/2024 documented that it was undetermined to believe that abuse, neglect, or mistreatment occurred, and the findings were inconclusive.When requested on 9/29/2025, the facility was unable to provide any additional documentation including additional interviews to clear inconsistencies and determine why the investigation conclusion was inconclusive. In an interview on 9/29/2025 at 4:50 PM, Resident #170 stated they were not familiar with incident and did not remember the staff member. Resident #170 stated they have had problems with some staff members and admitted to yelling, calling names and throwing items at them. Near the end of the interview after refreshing their recollection, Resident #170 remembered the gender of the registered nurse, and stated they may have been struck by Registered Nurse #12 while Registered Nurse #12 was blocking their throws. Resident #170 stated they had no stress about the incident.In a telephone interview on 09/30/2025 at 12:02 PM, Certified Nurse Aide #2 stated they did not remember everything about the incident. They remember hearing Resident #170 screaming at Registered Nurse #12 and Registered Nurse #12 told them to get the supervisor. Certified Nurse Aide #2 did not see anything physical between the Resident #170 and Registered Nurse #12 and did not remember telling Unit Manager #13 that Registered Nurse #12 was attacking the resident. They did not remember anyone questioning them 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. All people who were part of incident were to be interviewed. The investigator needed to learn the facts and try to determine a conclusion to the incident. If there were inaccurate or different versions of the story, then they must reinterview people to determine why there were different versions.10NYCRR 415.4(b)(3)

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	335809	A. Building B. Wing	11/20/2025

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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. Based on observation, interview and record review conducted during a recertification survey from 09/23/25 through 09/30/25, the facility did not ensure residents received the necessary assistance for bathing to maintain personal hygiene for 1 of 4 residents (Residents #114), reviewed for activities of daily living (ADLs). Specifically, Resident #114 did not receive twice weekly showers as scheduled. Findings include:The facility policy dated 1/4/25 titled Activities of Daily Living Support and Functioning documented residents will be provided with care, treatment, and services designed to maintain or improve their ability to carry out activities of daily living (ADLs), in accordance with their individualized care plans and assessed needs.Residents who are unable to perform ADLs independently will receive the necessary support to maintain optimal levels of nutrition, grooming, personal hygiene, and oral care, in line with their rights, preferences, and clinical conditions.Resident # 114 had diagnoses including Diabetes Mellitus, hypertension, and heart disease. The residents Minimum Data Set assessment tool dated 7/28/25 documented the resident had moderate cognitive impairment and a shower/bath was very important to them. The assessment documented the resident needed assistance with showering and bathing. Rejection of care was not identified on the assessment.During an interview with Resident #114 on 09/24/2025 at 11:05 AM they stated getting a shower was inconsistent and did not happen twice a week. They liked getting a shower and felt refreshed after the shower especially because they had an indwelling catheter. They stated staff would tell them there was not enough staff to give showers. The Activities of Daily Living Care Plan dated 7/11/24, documented the resident needed assistance with bathing and showers.The undated Certified Nurse Aide Kardex documented the resident was to receive a shower on Tuesday and Friday on the evening shift. Review of the Resident Certified Nurse Aide (CNA) Documentation History Detail from 06/1/25-9/29/25, revealed there were no shower documentation for evening showers. All bathing activities were performed and documented during the 7-3-day shift. In June 2025, Resident #114 received two showers and two bed baths; in July 2025, three sponge baths and one bed bath; in August 2025, two bed baths, one sponge bath and two days were left blank; and in September 2025, no showers, one bed bath and seven sponge baths. There was no documented evidence the resident refused any shower.During an interview on 09/26/2025 at 11:47 AM Certified Nurse Aide #14 stated they had not heard of an issue with giving the resident a shower and did not know why showers were not documented. During an interview on 09/26/2025 at 11:57 AM, the Assistant Director of Nursing #1 stated there was no reason the resident could not have a shower, and they should have been getting them twice a week. Showers should be documented in the Certified Nurse Aide Accountability Record. They stated they were not aware of any resident refusals. During an interview on 09/26/2025 at 2:50 PM, Certified Nurse Aide #1 stated they did not know why Resident #114 was not getting showers. They stated when there were only three (3) Certified Nurse Aides working on a shift, it was sometimes impossible to do showers and that could be a reason for so many sponge baths. 10 NYCRR 415.12(a)(3)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 a resident received proper treatment and assistive devices to maintain hearing. This was evident for 1 of 1residents (Resident #8) during review of communication. Specifically, nursing staff were unable to locate Resident #8's hearing aids after taking possession to charge and safekeep them for the resident overnight.The findings are: Resident #8had 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 Physician Orders dated 01/11/2024 documented Resident #8's hearing aids be applied in the morning and placed on their charger when removed every evening. The Audiology Consult dated 06/30/2025 documented Resident #8 received new hearing aids that facility staff must apply daily and remove for charging every evening. There was no documented evidence interventions to address Resident #8's hearing impairment and need for hearing aids accountability were developed and implemented. There was no documented evidence Resident #8's hearing aids were safely maintained by nursing staff to prevent them from going missing. On 09/24/2025 at 12:13 PM, Resident #8 was interviewed and stated they gave their hearing aids to the nursing staff a few weeks ago and the hearing aids went missing. Resident #8 reported the missing hearing aids to the Assistant Director of Nursing. Resident #8 stated nursing staff informed them a search was conducted but Resident #8's hearing aids were not found. On 09/25/2025 at 4:12 PM, Licensed Practical Nurse #24 was interviewed and stated a Physician's Order detailing hearing aid application and removal instructions was obtained for each resident with hearing aids. The order then populated the nursing administration record for the licensed nurses to sign daily when they applied and/or removed the resident's hearing aids. Licensed Practical Nurse #24 stated Resident #8's hearing aids went missing after the resident briefly moved to Licensed Practical Nurse #24's unit a few months ago. Licensed Practical Nurse #24 stated they informed the Assistant Director of Nursing when Resident #8's hearing aids went missing. On 09/25/2025 at 4:26 PM, Licensed Practical Nurse #15 was interviewed and stated Resident #8 was briefly transferred to another unit and then switched units again approximately one month ago. Licensed Practical Nurse #15 stated they were on vacation when Resident #8 discovered their hearing aids were missing and saw they were missing upon their return to work on 09/08/2025. Licensed Practical Nurse #15 stated they had possession of Resident #8's hearing aid charging dock, but the resident's hearing aides were still missing. During interview, an observation was made of the hearing aid charging dock at the nursing station labeled with Resident #8's name. Licensed Practical Nurse #15 stated no Audiology referral or appointment for replacement hearing aids was made for Resident #8. Resident #8 was not provided with any substitute hearing devices to aide Resident #8 while they await hearing aid replacement. On 09/25/2025 at 4:48 PM, the Assistant Director of Nursing was interviewed and stated they were able to determine that Resident #8's hearing aids went missing recently even though there was a Physician's Order for nursing staff to apply and to remove and charge Resident #8's hearing aids. No Audiology consult for hearing aid replacement had been ordered or scheduled. 10 NYCRR 415.12(a)(3)(b)(1-3)

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	335809	A. Building B. Wing	11/20/2025

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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. **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 (continued on next page)

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

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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	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 staff observing or intervening. The tactile stimulation board was observed behind the nursing station. On 09/29/2025 at 1:47 PM, Licensed Practical Nurse #15 was interviewed and stated Resident #14 displayed behaviors consistent with their dementia diagnosis and wandered into other resident rooms often. Resident #14's wandering behavior disrupted other residents on the unit, Licensed Practical Nurse #15 stated the interdisciplinary team decided to change Resident #14's room a few months ago so Resident #14 would be in the last room at the end of the hall away from other resident rooms. Licensed Practical Nurse #15 stated Resident #14 now consistently wandered into their old room and dressed in the current resident's clothing from the closet because they were used to being in that room. On 09/30/2025 at 10:06 AM, the Assistant Director of Nursing was interviewed and stated facility staff managed Resident #14's wandering behaviors by involving the resident in activities , rounding, engaging in conversation, and providing tactile stimulation for Resident #14 to work with something with their hands although engaging Resident #14's attention was short-lived. The Assistant Director of Nursing stated they did not know Resident #14's former job but resident #14 usually woke up between 4AM and 5AM and thought they had to go to work and would begin wandering the unit looking for their job. The Interdisciplinary team decided to change Resident #14's room to the furthest room at the end of the hallway to address the resident's wandering behavior. The Assistant Director of Nursing stated Resident #14 still wandered into other resident rooms including their former room and could not adjust to the location of their new room. The Assistant Director of Nursing stated the Recreation staff invited Resident #14 to various activities and Resident #14 especially enjoyed music. The Assistant Director of Nursing stated Resident #14 did not have their own portable music device or a device to play music in their room and was not aware of attempts to provide Resident #14 with music outside of regularly scheduled Recreation activities for the whole unit. Resident #14'S room had no bedside dresser or any other furniture that came standard in other resident rooms because Resident #14 liked to tinker with their hands and the staff feared Resident #14 would take apart the furniture in their room. On 09/30/2025 at 11:09 AM, the Director of Social Work was interviewed and stated Resident #14 presented with severe cognitive impairment since their admission to the facility but more recently, their dementia behaviors, including wandering into other resident rooms, worsened and increased in frequency. Recreation attempted to engage Resident #14 in group activities and visited with the resident one-on-one. The Director of Social Work stated they were not aware of any care plan interventions to address Resident #14's routine sleeping habits, such as waking up at 4AM or 5AM. The Director of Social Work stated the interdisciplinary team discussed transferring Resident #14 to another facility and multiple referrals were sent to facilities with specialized dementia units to transfer Resident #14 to a facility more suited for their needs. Resident #14 has not been accepted for admission by any other facility. On 09/30/2025 at 1:12 PM, the Medical Director was interviewed and stated Resident #14 did not have any neurology consults or follow-ups since their hospitalization in 08/2025. 10 NYCRR 415.12

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

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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. **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 (continued on next page)

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	335809	A. Building B. Wing	11/20/2025

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 Psychiatrist documented in their consults. The Medical Director stated Resident #14 had a diagnosis of dementia, but their psychotic symptoms made psychosis their primary diagnosis. The Medical Director stated they were previously unaware of the Psychiatrist's recommendation on 09/13/2025 to reduce Resident #14's Haldol order from 2 milligrams to 1 milligrams every six hours. 10 NYCRR 415.12(l)(1)

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	335809	A. Building B. Wing	11/20/2025

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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, interviews, and record review conducted during the recertification survey from 09/23/2025 to 09/30/2025, the facility did not ensure special eating equipment and utensils for a resident who need them was provided for 1 of 1 resident (Resident #3) reviewed for adaptive equipment. Specifically, built up utensils were not provided for Resident #3 as per physician order. The findings are:The facility policy and procedure titled Adaptive Equipment dated 08/02/25 documented the purpose was to ensure that residents receive the appropriate adaptive equipment and staff members are trained in its proper use. The residents need for adaptive equipment should be assessed and evaluated by a qualified rehabilitation therapist. Following the assessment, the rehabilitation therapist should prescribe the specific equipment required. The responsible staff should promptly place an order, care plan and appropriate task for the adaptive equipment with the supplier, vendor.Resident #3 had diagnoses including Chronic Obstructive Pulmonary Disease, Diabetes Mellitus and Muscle weakness.The Minimum Data Set assessment tool dated 4/22/2025 documented the resident had severe cognitive impairment and required partial to moderate assistance with eating.The physician order dated 05/23/2025 documented built-up utensils to be provided during meals to increase independence with self-feeding. The Nutrition Risk care plan updated 5/23/2025 documented built-up utensils to be provided during meals to increase independence and safety with self-feeding. A Dietician note dated 9/13/2025 documented the resident's weight was 138.7 pounds; the resident was underweight and had an insignificant weight loss of 6.7% over six months. Diet was regular texture with thin liquids. Supplements included Ensure Plus high protein twice a day. The resident's appetite was fair, plan of care ongoing. During an observation on 09/23/2025 at 12:26 PM the resident's lunch meal was set up and the resident was observed picking at meal with a fork. During a lunch observation on 09/25/2025 at 12:18 PM, the resident was eating their meal, no built-up utensils were noted on the tray. The meal ticket was reviewed and there was no documentation of built-up tools to be used for the resident. During an observation on 09/29/2025 at12:36 PM, the resident was eating their lunch with a chunky spoon built up tool in use. They were able to hold the spoon handle better than when observed without. The resident ate well with the tool.During an interview on 09/25/25 at 12:21PM, Licensed Practical Nurse#15 stated the special tools came from the kitchen and were put on the trays by the kitchen staff after the Speech Therapist did an evaluation. They were not aware of a list of residents who were provided tools to be used during meals. They stated the Dietician would also let the staff know who needed tools for meals. They were not aware Resident #3 needed special equipment to eat their meal.During an interview with on 09/25/25 at 3:16 PM, Dietician #1 stated the built-up tools came from the kitchen and the Occupational Therapist provided a list of residents with the tools. The Dietician stated if a resident had an order for built up tools, then they should have been on the resident's tray. They were not aware Resident #3 needed built up tools for meals. During an interview with the Director of Rehabilitation on 09/26/2025 at 9:26AM they stated they were the one who evaluated Resident #3 for built up tools in May and recommended the built-up tool for eating. They placed an order in the resident's record and updated the care plan, but they did not inform the kitchen and the resident's name was not added to the master list. They stated the resident fell through the crack. They did not notice the resident did not have the tool while on their rounds but did follow up on residents who had the equipment and see if they were using it properly. 10 NYCRR 415.14 (g)

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	335809	A. Building B. Wing	11/20/2025

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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. Based on observation, record review, and interview during the recertification survey conducted 9/23/25 to 09/30/25, the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 4 residents (Resident #12) reviewed for activities of daily living. Specifically, staff were observed transferring Resident #12 from the bed to chair in a lift and not wearing the required personal protective equipment for Enhanced Barrier Precautions. Findings include: The facility policy for Enhanced Barrier Precautions dated 08/05/25 documented Enhanced Barrier Precautions are used as an infection prevention and control intervention to reduce the transmission of multi drug resistant organisms to residents. Enhanced Barrier Precautions employ targeted gown and glove use in addition to standard precautions during high contact resident care activities. Examples of high contact resident care activities requiring the use of a gown and gloves include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs, device care or use, wound care. Resident #12 had diagnoses including dementia, chronic obstructive pulmonary disease and major depressive disorder.The residents Minimum Data Set assessment tool dated 8/28/25 documented the resident had cognitive impairment and was dependent on staff for eating, toileting, showering and transferring to chair. The residents care plan for skin breakdown dated 07/17/25 documented the resident had skin tears on lower extremities and interventions included wear gown and gloves during assistance with bathing, transferring, changing of briefs, linens and during wound care. The Physician orders document the resident is on Enhanced Barrier Precautions. During an observation on 09/25/2025 at 11:23 AM Resident #12 room door had a sign indicating the resident was on Enhanced Barrier Precautions. The sign included directions to wear a gown for transferring residents. Home Health Aide #18 and #19 and Certified Nurse Aide #17 were observed transferring the resident without wearing a gown. The resident's legs were bare and gauze wraps were in place. During an interview on 09/25/25 at 11:28AM Home HealthAide#19 stated they were just in serviced on 09/24/25 about hand washing, all types of Personal Protective Equipment and how to don and doff used equipment. They were not aware they needed to wear gowns for transferring residents. During an interview on 09/25/25 at 12:07AM The Infection Preventionist stated they did an in service on 09/24/25 with the Home Health Aides which included Enhanced Barrier Precautions. They let the Home Health Aides know that residents with openings on their body need Personal Protective Equipment when providing care including transfers. During a second interview on 09/29/2025 at 3:43 PM they stated they were doing more in services with staff and rounding because they could see that staff need constant reminding about precautions and Personal Protective Equipment use.