STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335810	A. Building B. Wing	12/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lutheran Center at Poughkeepsie Inc	965 Dutchess Turnpike Poughkeepsie, NY 12603

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews during an abbreviated survey (2625335), the facility did not ensure assessments accurately reflected the resident's status for 1 out of 3 residents (Resident #1) reviewed for assessments. Specifically, Resident #1 had a Physical Therapy evaluation in the facility on 08/22/2025 and was found to require maximum assistance for bed mobility. However, an admission Minimum Data Set, dated [DATE] documented Resident #1 as dependent for bed mobility on their functional assessment. The findings are: The facility did not have a policy related to the Minimum Data Set assessment.Resident #1 was admitted with diagnoses including but not limited to Dementia, Unspecified Intracapsular fracture of right femur and Type 2 Diabetes Mellitus. An Admission/Medicare 5 Day Minimum Data Set, dated [DATE] documented Resident #1 had severe cognitive impairment. The resident had impairment to the lower extremity on one side and required a walker or a wheelchair for locomotion. The resident required set up assistance with meals and was dependent for toileting, bed mobility and transfers. The resident was not on a turning and positioning program. Review of the activities of daily living care plan dated 08/20/2025 documented Resident #1 had a self-care performance deficit related to activity intolerance, confusion and disease processes. Interventions listed included to encourage the resident to fully participate possible with each interaction and praise all efforts of self-care. Review of a rehabilitation progress note dated 08/22/2025 at 12:32 PM documented Resident #1 was evaluated for Physical Therapy and was found to have the following mobility levels: maximum assistance for bed mobility, sit to stand pivot transfers are a maximum assistant of two people, toilet transfers with extensive assistance of two people. Resident #1 was currently not ambulatory and was dependent for wheelchair mobility. During an interview on 10/09/2025 at 11:37 AM, Licensed Practical Nurse #1 stated Resident #1 was mobility dependent. During an interview on 10/9/2025 at 12:56 PM, Registered Nurse #2 stated in the functional assessment section of the minimum data set, the rehabilitation department completes this section, and it is then signed off by nursing. Registered Nurse #2 stated an entry for Resident #1 was coded as dependent for bed mobility and they would think the resident would have turning and positioning orders or have their heels elevated. Attempts to reach Physical Therapist #1 on 10/23/2025 was unsuccessful. 10 NYCRR 415.11(b)

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (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 0686 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure a resident received care consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable for one (1) out of three (3) residents (Resident #1) reviewed for pressure ulcers. Specifically, on 08/20/2025, Resident #1 was assessed as having a blanchable area of moisture associated skin damage to their coccyx/buttocks, was dependent for bed mobility, had no interventions implemented and was later diagnosed with an unstageable pressure ulcer. Additionally, Resident #1 had functional limitations with an order to have their feet offloaded while in bed, which was not consistently done resulting in a deep tissue injury to the resident's right heel. This resulted in actual harm to Resident #1 that was not Immediate Jeopardy. The findings are:The facility Pressure related Injury Prevention and Treatment and Wound Management policy, last revised 11/2018, documented the organization is committed to providing a comprehensive wound management program to promote the resident's highest level of functioning and well-being and to minimize the development of in-house acquired pressure ulcers, unless the individual's clinical condition demonstrates they are avoidable. Any resident with a wound receives treatment and services consistent with the resident's goals of treatment. Risk reduction measures such as turn and position schedule and the use of heel protectors for offloading are initiated if determined appropriate.Resident #1 was admitted with diagnoses including but not limited to dementia, unspecified intracapsular fracture of right femur (hip fracture) and Type 2 diabetes mellitus. Review of skin integrity care plan initiated on 08/20/2025 documented that Resident #1 had potential for impairment to skin integrity. Interventions listed included biweekly skin checks, keeping skin clean and dry, monitoring for signs of infection or drainage and informing the physician of any abnormalities. Review of activities of daily living care plan initiated 08/20/2025 documented Resident #1 had a self-care performance deficit related to activity intolerance, confusion and disease processes. Interventions listed included encourage the resident to fully participate to extent possible with each interaction and praise all efforts of self-care. Review of Resident #1's admission skin assessment, dated 08/20/2025, documented the resident had scattered ecchymosis to their bilateral extremities and a blanchable area of moisture associated skin damage to their coccyx/buttocks area. Review of a Braden Scale for predicting pressure ulcer risk evaluation, dated 08/20/2025 at 1:09 PM, documented the following: Sensory perception-very limited, Moisture-occasionally moist, Activity-chair fast. Resident #1 is very limited-makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently. Nutrition-adequate, friction and shear-potential problem. Braden score: 14.0, indicating a moderate risk. Review of a Physician's order dated 08/20/2025 documented monitor skin observations every shift. Review of a wound management care plan initiated 08/21/2025 documented Resident #1 had blanchable moisture associated skin damage to their coccyx area. Interventions listed included providing the resident with an alternating air mattress and per the Nurse Practitioner, cleanse the area with normal saline, apply Santyl (a medication that helps remove dead skin tissue and aids in wound healing) then cover with a foam dressing daily and as needed. An Admission/Medicare Five (5) Day Minimum Data Set, dated [DATE], documented Resident #1 had severe cognitive impairment. The resident had impairment to the lower extremity on one side and required a walker or a wheelchair for locomotion. The resident required set up assistance with meals and was dependent for toileting, bed mobility and transfers. Resident #1 was identified as at risk for developing pressure ulcers/injuries, but had none present on admission. Resident #1 had a pressure relieving device in their wheelchair and bed. There was no documented evidence of orders for turning and repositioning and or risk reduction measures such as turning and positioning. Review of Nurse Practitioner #1's progress note, dated 08/28/2025 at 12:02 PM, documented Resident #1 was seen for an open area on their left buttocks. The note documented the area was not a reopened area but was a Stage 2 pressure injury. The measurements were as follows: Size- 3.1 cm by 1.4 cm, no tunneling or undermining. Appearance-epithelial tissue, moist red and yellow. No odor, no exudate with scant drainage and the progression of healing was stable. Interventions listed included to ensure functioning of the air mattress every shift. Review of Resident #1's certified nurse aide accountability for August 2025 revealed skin observation was not signed by direct care staff as being performed on nine (9) occasions. Further review of the certified nurse aide accountability on 08/28/2025 documented on the evening shift that the resident had skin redness, and no skin findings were documented

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on record review and interviews during an abbreviated survey (2625335), the facility administrator did not ensure they used its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically, during an abbreviated survey, the facility did not provide requested facility policies to the Surveyor on-site. The Director of Nursing stated there is no documented facility policy for the following: Braden scale assessments, skin observation, admission assessments or a Minimum Data Set Assessment policy.The findings are: During an interview on 10/9/2025 at 1:00 PM, the Director of Nursing stated they do not have a policy related to Braden scale assessments and it is a Corporate issue. The Director of Nursing stated they are doing their best and will try to address all these issues brought up during the onsite survey. The Director of Nursing stated the facility does not have a skin observation policy or an admission assessment policy. They were not sure if the facility has a minimum data set policy and they know this is a problem, but it is a corporate issue. The Director of Nursing stated they are trying to make changes and update the facility policies. The Director of Nursing stated they asked the Administrator about the policies requested and was informed that they did not need a policy for everything in the facility. 10 NYCRR 415.26