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	04/14/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews during the survey, the facility did not ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for one (1) of three (3) residents (Resident #147) reviewed for Urinary Tract Infection, one (1) of three (3) residents (Resident #13) reviewed for Position/Mobility, and one (1) of one (1) resident (Resident #12) reviewed for Anticoagulation. Specifically, 1) Resident #147 was exhibiting symptoms of a urinary tract infect, urine samples for testing were not collected as ordered and the antibiotic was started prior to the sample collection; 2) Resident #13 was evaluated and waiting for a fitting for new orthotics which was delayed due to untimely follow up by the facility; 3) Resident #12 refused to continue their anticoagulant. There was no documented evidence that education was provided on the possible effects of discontinuation, or that the care plan was updated to reflect the discontinuation of the medication. The findings included:1) Resident #147 had diagnoses that included cirrhosis (liver disease), right hip fracture, and colostomy. The admission Minimum Data Set, dated [DATE] documented intact cognition, maximal assistance with toileting hygiene, and occasionally incontinent of bladder. The physician note dated 01/30/2026 at 10:35AM documented resident was seen for follow up due to elevated white blood cell count and reported burning and frequency with urination. Do urine dipstick, obtain urinalysis and culture if dipstick positive, start Zosyn 3.375gm every six (6) hours for five (5) days.The nursing note dated 1/30/2026 at 11:02AM documented that Resident #12 was seen by the physician. Per physician, do urine dipstick, if positive obtain urinalysis and culture, do chest x-ray, start Zosyn 3.375gm every six (6) hours for five (5) days. The medication administration record for January 2026 documented the physician order for piperacillin sodium tazobactam (Zosyn) solution 3.375 gram every six (6) hours for urinary tract infection for five (5) days. The first dose was signed for on 01/30/2026 at 6:00PM.The lab result dated 02/05/2026 documented that a urine sample was collected and submitted for the urinalysis and urine culture on 02/03/2026. The culture documented an insignificant count of bacteria.During an interview on 04/10/2026 at 1:48 PM, Physician #1 stated that it was best to collect the urine sample before starting antibiotic treatment but may start the antibiotic before the results are back. They often perform a urine dipstick at the facility to get a preliminary reading and did request that one be performed for Resident #147 on 01/30/2026.During an interview on 04/14/2026 at 11:46 AM, Licensed Practical Nurse Unit Manager #1 stated that the physician ordered a urine dipstick before the urinalysis and culture for Resident #147 on 01/30/2026, but they were unable to find any documented evidence of the dipstick being completed. They stated they did collect the urine for the urinalysis and culture on 01/30/2026 but that sample could not be processed because it was not picked up by the lab in time. There was no documented evidence of the collection on 01/30/2026. A urine sample was obtained again on 02/03/2026 after the antibiotic had already started.2) Resident # 13 had diagnoses that included spinal stenosis, paraplegia, and scoliosis. The Quarterly Minimum Data Set, dated [DATE] documented intact cognition and supervision or touch assistance required for chair-to-chair transfers. The physician note dated 03/24/2026 documented the resident had poor tolerance of Ankle (continued on next page)

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

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

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	04/14/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Foot Orthoses, replacement Ankle Foot Orthoses were necessary. The physician order dated 03/26/2026 documented bilateral Ankle Foot Orthosis.During an interview on 04/06/2026 at 12:00 PM, Resident #13 stated that they used bilateral lower extremity orthotics. They discussed getting a new set that provided more comfort and enclosed shoes. The ones that they had could not be repaired. Therapy was handling the replacement, but they had not received any recent updates and would like to.During an interview on 04/09/2026 at 9:59 AM, the Director of Rehabilitation stated that they had been working on getting a new set of orthotics for Resident #13 because modification of the pair they had was not possible. They received an email from the orthotics company on 03/04/2026 which read that the next orthotics appointment was scheduled for 03/12/2026 and the prescription and physician note were needed before the appointment. On 03/11/2026 they received another email from the orthotics company that read that the appointment on 03/12/2026 had to be postponed because the necessary paperwork had not been received. The Director of Rehabilitation for Long Term Care should have the correspondence with the company after that. During an interview on 04/09/2026 at 10:07 AM, the Director Rehabilitation for Long Term Care stated that they did request the physician note and order a few weeks ago and they were completed, they just did not forward them to the orthotics company yet. Once the orthotics company received the order and physician note, they could make an appointment for the orthotics company to return for the casting of the orthotics. They stated they will get those out to the orthotics company and update Resident #13 on the status.3) Resident #12 had diagnoses that included atrial fibrillation, heart failure, and generalized weakness. The Five-Day Minimum Data Set, dated [DATE] documented intact cognition and medications included anticoagulant. The Anticoagulation care plan dated 03/18/2026 documented prescribed Eliquis. The goal was that resident will show no signs or symptoms of bleeding. Interventions included, but not limited to, monitoring for signs of bleeding, evaluate for bruising, monitor labs as ordered.The physician order dated 03/26/2026 documented Eliquis five (5) milligrams every 12 hours for atrial fibrillation. The order was discontinued on 04/02/2026. The physician order dated 04/03/2026 documented aspirin 81 milligrams, one (1) tablet by mouth one time per day for anticoagulation. During an observation on 04/06/2026 at 9:39 PM, Resident #12 was observed with bruising to their bilateral upper extremities. During an interview on 04/06/2026 at 2:39PM, Resident #12 stated that they requested that their order for Eliquis be discontinued.During an interview on 04/10/2026 at 11:32 AM, Licensed Practical Nurse #13 stated that Resident #12 was on Eliquis but was refusing the medication and the physician was aware. They stated that the resident was now on aspirin. They were unable to find any nursing or physician progress notes that the resident was refusing or that there was education or discussion about the medication and possible effects of discontinuation. During an interview on 04/10/2026 at 12:00 PM, Licensed Practical Nurse Unit Manager #16 stated that they did speak to Resident #12 about the potential effects of discontinuing the Eliquis when they were refusing and prior to discontinuation, but failed to write a note or update the care plan. They stated they should have entered a note and updated the care plan at that time and would do that now.During an interview on 04/14/2026 at 11:14 AM, the Director of Nursing stated that documentation of the education of stopping Eliquis and an update to the care plan should have been completed for Resident #12 when the Eliquis was discontinued.10NYCRR 415.12

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	04/14/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview conducted during survey, the facility failed to ensure each resident received adequate supervision and consistent with resident needs to prevent accidents for two (2) of four (4) residents (Resident #9, Resident #8) reviewed for accidents. Specifically, on 03/25/2026, Resident #9 left the facility though an alarmed fire door, staff did not respond for over three (3) minutes to the alarm, and the resident fell in the parking lot and was found bleeding with abrasions to their forehead, nose and knees. 2) Resident #8 was at high risk for falls and care planned to be in the dining room in view of staff. On 04/07/2026, the resident fell in the dining room and sustained a large bump on the forehead while the certified nurse aide providing supervision was looking at their phone and out the window. This resulted in actual harm to Resident #8 and #9 that was not Immediate Jeopardy. Findings include: The facility policy Elopement / Wandering, last reviewed 12/2025, documented the purpose of the policy was to promote the safety of all residents, notification of appropriate parties, and to train and maintain staff awareness of the importance of resident safety and security. Elopement is defined as the ability of a dependent resident to successfully leave the facility unsupervised and unnoticed. 1) Resident #9 had medical diagnoses including encephalopathy (brain dysfunction) dementia, and gait/walking difficulties. A quarterly Minimum Data Set (a resident assessment tool) dated 01/26/2026 documented Resident #9 had severely impaired cognition. The Wander Risk Scale dated 05/09/2025 documented Resident #9 was at risk to wander and was confused, wandered on the unit and in and out of other residents' rooms. The physician order dated 05/16/2025 documented Resident #9 had an electronic monitoring device, and it was to be checked every shift. Physician orders dated 05/27/2025 documented Resident #9 was to receive one-to-one (1:1) staff supervision as needed for increased agitation, wandering and/or exit seeking. Resident #9's care plan The resident has impaired cognitive function/dementia or impaired thought processes related dementia dated 05/09/2025 documented the resident would develop skills to cope with cognitive decline and maintain safety. Resident #9's care plan Risk for wandering related to dementia dated 05/12/2025 documented the resident was often looking for car and car keys. Interventions included an electronic monitoring device to their left ankle, disguised exit doors, to monitor Resident #9's location every hour and to redirect calmly if they enter another resident's room. Resident #9's care plan The resident is an elopement risk/wanderer dated 08/28/2025 documented the resident would not leave facility unattended, and the resident's safety would be maintained. Interventions included disguising exits and providing structured activities. The elopement evaluation dated 01/26/2026, documented Resident #9 was identified as an elopement (continued on next page)

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	04/14/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	risk. A score of one (1) or higher indicates Risk of Elopement, Resident #9 scored seven (7) out of nine (9). The Incident & Accident form, dated 03/25/2026, and Registered Nurse Supervisor #8's nursing progress note dated 03/25/2026 at 8:30 PM, documented at 7:00 PM Resident #9 had an unwitnessed fall and elopement and was observed lying on their left side in the south side parking lot. Licensed Practical Nurse #24 reported to Registered Nurse Supervisor #8. The report documented that Resident #9 had a laceration on their forehead and an abrasion to the nose. Resident #9 stated they were looking for their truck. The resident's electronic monitoring device was in place. The resident was transferred to the hospital for further evaluation. Licensed Practical Nurse #24's progress note dated 03/25/0226 at 9:52 PM documented they were returning to the unit, entered the floor to an alarm blaring and Licensed Practical Nurse #25 was at the entrance checking the alarm. Licensed Practical Nurse #24 told Certified Nurse Aide #26 to check Hallway #2. At the nurses' station, the alarm panel showed the alert coming from Hallway #3. They went in that direction and opened the door, checked surroundings and found Resident #9 lying on their left side and bleeding from the face. Registered Nurse Supervisor #8 and Licensed Practical Nurse #25 were alerted. Registered Nurse Supervisor #8 assessed the resident and emergency medical service was called. Resident #9 was transported to the hospital. Certified Nurse Aide #27's statement dated 03/25/2026 documented they were with another resident at the time of the incident and the last time they saw the resident was during dinner. Resident #9 kept repeating being told to sit down and slow down; he was mad about finding his car. Certified Nurse Aide #21's statement dated 03/25/2026 documented they were coming back from cardiopulmonary resuscitation class at the time of the incident. The last time they saw Resident #9 was during dinner and the resident was asking for their truck. Licensed Practical Nurse #25's statement dated 03/25/2026 documented they were doing a medication pass then were at the nursing station at the time of the incident. The last time they saw Resident #9 was in the dining room and they were asking for their truck. Certified Nurse Aide #22's statement dated 03/25/2026 documented they were Resident #9's assigned certified nurse aide and the last time they saw the resident was during dinner. Certified Nurse Aides #26 and #23's statements dated 03/25/2026 documented they were taking care of other residents at the time of the incident and the last time they saw Resident #9 was at dinner. Both statements documented that they did not notice anything about the resident's behavior. The emergency department physician note dated 03/26/2026 documented the resident stated they fell and their face hurt. Symptoms included pain localized to a facial abrasion, bilateral knee discomfort with motion, and mild pain high on the right posterior neck/occiput region. The resident underwent computed tomography (CT) scans of the head, maxillofacial (jaws and face) and cervical (neck) spine and received a Tdap (tetanus, diphtheria, and whooping cough) vaccine. The wounds were cleansed, and the resident was discharged back to the facility when imaging came back negative. Medical Doctor #2's progress note dated 03/26/2026 at 8:49 PM documented Resident #9 was seen for evaluation of a fall that happened yesterday. Resident #9 received skin abrasions on their forehead (continued on next page)

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	04/14/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	and bilateral knees and left shoulder. Resident #9 denied any complaints except some pain in the knees, shoulder and forehead. Medical Doctor #2 ordered to monitor vital signs, added neurological checks every shift for three (3) days and standing order for Tylenol 650 milligrams every eight (8) hours for ten (10) days. The physician order dated 03/26/2026 documented two (2) Tylenol 325 milligram tablets every eight (8) hours for pain for 10 days. Additionally, there were orders for Bacitracin (topical antibiotic) ointment to the face, left shoulder, and bilateral knees topically two (2) times a day for abrasions. The facility investigation submitted to the New York State Department of Health on 03/26/2026, documented an elopement on 03/25/2026 with the last time the resident was seen as 7:00 PM. The investigation documented the system to prevent elopement functioned properly and the resident returned. The resident was observed lying in the parking lot at 7:05 PM, was alert and stated they were looking for their truck. Abrasion noted to the nose, laceration noted to the forehead, pressure dressing applied and transferred to the hospital to rule out injuries, returned to the facility with no major injuries. The camera footage showed Resident #9 open the fire exit door at 7:02 PM and went outside to the parking lot. Licensed Practical Nurse #25 started looking for the resident at approximately 7:03 PM. Licensed Practical Nurse #24 instructed Certified Nurse Aide #26 to go to Hallway #2 to check. Licensed Practical Nurse #24 looked at the nurse's station alarm panel which showed the alert coming from Hallway 3. Licensed Practical Nurse #24 went in that direction and opened the door at 7:05 PM and observed Resident #9 lying on the ground in the parking lot. Immediate response and plan to prevent recurrence included: Resident #9 was assessed by Registered Nurse Supervisor #8 and sent to the hospital. Education was immediately initiated with staff upon notification of the incident. Fire exit doors were supervised by the staff immediately and after the incident and one to one (1:1) supervision with the resident upon return from the hospital. The unit census was counted and made sure all other residents were safe. Doors were continuously monitored. During an observation on 04/06/2026 at 12:30 PM, Resident #9 stood up in the dining room and stated they had to find their car. The resident was redirected by staff. During an interview and observation on 4/09/2026 at 10:24 AM, Licensed Practical Nurse #6 stated Resident #9 left the facility and fell outside on 03/25/2026. Resident #9 had an electronic monitoring device, but the electronic monitoring device did not prevent the fire exit door from opening. Fire exit doors could be pushed open and then the alarm goes off. Residents could exit the fire door, walk six (6) feet to a second unlocked door and exit the building into the parking lot. The facility front doors and other doors would lock when a resident with an electronic monitoring device was near the door. Licensed Practical Nurse #6 demonstrated opening the fire door and the alarm went off; it was loud, and another staff responded instantly. They stated the alarm would continue to sound until it was turned off by staff. During observation of camera footage on 04/13/2026 at 12:01 PM, the Director of Nursing was present and provided names of staff and residents during the observation; the video was stamped with date and time. On 03/25/2026 at 7:01 PM, Hallway #3 had a vacant med cart against the wall at the end of the hallway closest to the nurses' station. Resident #9 walked down the hallway, past the fire door to the sitting area, and then turned back around and went to the fire exit door. The resident exited at 7:02 PM. At 7:02:36 PM, a visitor walked down the hall and entered the resident room across from the fire door that Resident #9 exited. At 7:03:38 PM, another resident was seen wheeling in their wheelchair and stopped in the hallway next to the med cart. At 7:04:10 PM, Certified Nurse Aide #27 pushed Resident #97's wheelchair, going around the other resident, and into a resident room. Certified (continued on next page)

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	04/14/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	Nurse Aide #27 came out of the room, walked across the hall, in and out of another resident room, then grabbed towels off the linen cart and went back in Resident #97's room. At 7:05:04, Licensed Practical Nurse #24 walked down the hall and exited though the fire door at 7:05:17 PM. At 7:06 PM, Licensed Practical Nurse #25 ran down the hall, exited, and came back in at 7:07:57 PM. The Director of Nursing stated there were no camaras outside to review. During an interview on 04/13/2026 from 12:09 PM to 12:56 PM, the Director of Nursing stated staff should have responded when the fire alarm sounded. They stated Certified Nurse Aide #27 said they did not hear the alarm. Certified Nurse Aide #22 said they were in a room giving resident care and the radio was loud. Certified Nurse Aide #26 said they were in a room giving care and the TV was loud, so they did not hear the alarm. Licensed Practical Nurse #25 said they were giving medications. Licensed Practical Nurse #24 and Certified Nurse Aide # 21 were at the cardiopulmonary resuscitation class and when they returned to the unit the alarm was going off. Licensed Practical Nurse #24 went to the panel and saw it was Hallway #3 and went out the fire door and found the resident in the parking lot. Licensed Practical Nurse #24 called the Supervisor, and they went to the parking lot to assess the resident and sent the resident to the hospital. The Director of Nursing stated the resident always wanted to get their car or truck and had not pushed the fire door before. They stated the electronic monitoring device did not work on fire doors; it was for the front door and patio doors. At those doors, there are alarms and locks. Usually, staff were able to redirect residents. Resident #9 was now on one-to-one (1:1) supervision. They stated after the incident; all staff were educated by the Director of Nursing and Director of Maintenance. Certified Nurse Aide #27 was new, and their probation was extended and Licensed Practical Nurse #25 was terminated. They stated they were looking at fire doors that had a delayed opening when pushed. During an interview on 04/13/2026 at 2:25 PM, Certified Nurse Aide #27 stated when the fire door opened it made a loud noise that was different from the noise made when residents with electronic monitoring device triggered the front door. They stated they were familiar with the noise made when the electronic monitoring device triggered the front door, but they were not familiar with the sound of the fire doors. They stated the alarm went off when they had just finished a resident's care and were getting ready to do Resident #97's care. They saw Licensed Practical Nurse #25 sitting at the nurses' station and since Licensed Practical Nurse #25 was eating, and not reacting to the alarm, they did not know what was going on and took care of Resident #97. During interview and observation on 04/13/2026 at 3:00 PM, Licensed Practical Nurse #6 walked out the door Resident #9 exited on 03/25/2026 and pointed to where on the parking lot the resident was found. Using a measuring tape, Licensed Practical Nurse #6 assisted in measuring the area from the door to the parking lot where the resident was found. The shortest distance using a straight line was 114 feet and would include walking across the grass, a landscaped area with mulch, and across the sidewalk in front of the parking lot. During an interview on 04/13/2026 at 3:10 PM, Certified Nurse Aide #22 stated they were assigned to Resident #9. After dinner they were putting residents to bed when Resident #9 went to the front door first and was brought back and put in the dining room across from the nurses' station where Licensed Practical Nurse #25 was eating at the desk. They went into a room to give another resident care and did not hear the alarm. They stated they saw Resident #9 after the incident when staff brought them to the unit in a wheelchair. They stated the resident's face was bloody and the ambulance was called. During an interview on 04/13/2026 at 3:35 PM, Licensed Practical Nurse #24 stated they were at a cardiopulmonary resuscitation class and when they got to the unit, the alarm was blaring. They (continued on next page)

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	04/14/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	checked the panel at the nurses' station and saw it blinking for Hallway 3. They went out the fire door and found the resident lying on their side on the ground. They called Registered Nurse Supervisor #8 who assessed, and Certified Nurse Aide #26 came with a wheelchair. The resident was taken back inside, Registered Nurse Supervisor #8 took care of the wounds, emergency medical service was called, and the resident went to the hospital. During an interview on 04/14/2026 at 1:16 PM, Medical Doctor #2 stated they were informed on the next day of Resident #9's elopement and fall with injuries. On 03/26/2026, Medical Doctor #2 examined the resident and saw the bruises on the forehead, elbow and knees. The resident was in some pain and Tylenol was prescribed. The resident had a history of falls, had a shuffling gait and the shuffling gait on a grass area was a problem for them, making it easier to trip. During an interview on 04/14/2026 at 3:25 PM, Registered Nurse Supervisor #8 stated they were told that Resident #9 had fallen outside. They went to the south side parking lot and found Resident #9 lying on their stomach. Resident #9 was assessed and found to have a laceration to the forehead, abrasions to the nose and cheeks. Resident #9 hit their head on the concrete and had blood coming from the forehead laceration. Resident #9 was assisted into a wheelchair and brought back into the facility. A pressure dressing was applied to the resident's forehead and Resident #9 was given Tylenol for comfort. Emergency medical service arrived and transported Resident #9 to the hospital for evaluation and treatment. 2) Resident #8 had diagnoses including renal failure (kidney failure), dialysis (process of removing toxins from the blood), and rib fractures (broken bones). The Five-Day Minimum Data Set, dated [DATE] documented intact cognition, supervision/touch assistance for transfers, fall in last month and last two (2) to six (6) months prior to entry, and fracture related to fall prior to entry. The resident's at risk for falls care plan (initiated 03/01/2026) documented Resident #8 was at high risk for falls. The resident had falls on 03/11/2026, 03/16/2026, 03/18/2026, 03/19/2026, 04/01/2026, 04/05/2026, and 04/07/2026. Interventions were updated after each fall and included remaining in the dining room and in view of staff, continue therapy for strengthening, Dycem (surface pad to prevent sliding) for wheelchair, encourage compliance with call bell, keep call bell in reach, and low bed. The fall risk assessment dated [DATE] documented resident high risk for falls. During an observation and interview on 04/06/2026 at 10:59 AM, there was bruising under both of Resident #8's eyes and left forehead. Resident #8 stated that the bruising was from a fall sustained when they were getting out of bed. The Accident and Incident Report dated 04/07/2026 documented that Resident #8 sustained an unwitnessed fall in the dining room on 04/07/2026 at 6:55 AM that resulted in a large bump to the forehead. Statements from staff, a rehabilitation referral, nursing notes, and care plan updates were attached to the report. The statement from Certified Nurse Aide #10 documented that they last saw Resident #8 at 6:30 AM in the dining room. Licensed Practical Nurse #18's progress note dated 04/07/2026 at 8:45 AM, documented that on 04/07/2026 that at approximately 6:55 AM, Resident #8 was on the floor in front of their wheelchair in (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335810	A. Building B. Wing	04/14/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	the dining room lying on their right side. Resident #8 was alert and verbal with no complaints of pain. Registered Nurse Supervisor #19 was notified and came to the unit to assess. Vital signs were obtained. A raised area to their right forehead was noted. Ice pack applied to forehead by staff. Three (3) staff assisted the resident back to the wheelchair. Registered Nurse Supervisor #19's progress note dated 04/07/2026 at 7:40 AM documented on 04/07/2026 they were called to assess Resident #8 who was observed on the floor in the dining room at 6:55 AM and had sustained a big bump on their forehead. Resident #8 verbalized I tried to walk and fell. Ice packed applied and Tylenol administered for pain. Resident #8 was alert, verbal, and non-compliant. Assisted back to wheelchair with three (3) person assist, for rehab reevaluation due to multiple falls, resident kept in the dining area visible to staff and for close monitoring. Family and physician notified. During an observation on 04/08/2026 at 12:31 PM, Resident #8 was sitting in the dining room for lunch in a wheelchair, bruising noted to both sides of their forehead. During an interview with the Director of Nursing on 04/09/2026 at 4:18 PM, the Director of Nursing stated Resident #8 was at high risk for falls, had multiple falls, and they had added new interventions for Resident #8 after each fall. They stated their most recent fall was on 04/07/2026 and they have now added one-to-one (1:1) supervision in the morning. During an interview and observation on 04/10/2026 at 10:50 AM, the Director of Nursing provided the requested disciplinary file for Certified Nurse Aide #10 and stated that they had been written up. The disciplinary action documented a written warning on 04/08/2026 for poor work performance and failure to tend to Resident #8 timely during a fall on 04/07/2026. It documented that Certified Nurse Aide #10 was present but not actively supervising Resident #8 as they should have been resulting in a fall and head injury. During an interview and observation on 04/14/2026 at 10:41 AM, video footage from the 2 South dining room on 04/07/2026 starting at 6:42 AM was reviewed with the Director of Nursing. The Director of Nursing stated that they had reviewed the footage because they wanted to determine how the resident fell. The 2 South unit staff were aware of Resident #8's risk of falls and history of multiple falls. In the video footage, Certified Nurse Aide #10 and Resident #8 were observed in the dining room at 6:43 AM, Certified Nurse Aide #10 was sitting at a table by a window and Resident #8 was sitting in a wheelchair close to a table in the center of the room, out of arms reach to Certified Nurse Aide #10 who was looking at their phone and looking out the window. Resident #8 was leaning forward in the wheelchair intermittently. At 6:51 AM, Certified Nurse Aide #10 remained sitting at the table away from Resident #8 when they leaned forward and fell out of the wheelchair to the floor. At 6:52 AM, Licensed Practical Nurse #18, Registered Nurse Supervisor #19, and the Director of Nursing were all observed reporting to the unit and assessed Resident #8. The Director of Nursing stated that Certified Nurse Aide #10 should have been supervising Resident #8 more closely and not looking at their phone and out the window. During a telephone interview on 04/14/2026 at 3:08 PM, Certified Nurse Aide #10 stated that they were not the assigned aide for Resident #8 on the morning of 04/07/2026 but agreed to supervise them in the dining room. They were aware that Resident #8 was at high risk for falls. They did not move Resident #8 closer to them because they were sleeping in the wheelchair near a table and they did not think Resident #8 would fall. 10 New York Codes Rules Regulations 415.12 (h)(2)