STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335824	A. Building B. Wing	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Putnam Ridge	46 MT Ebo Road North Brewster, NY 10509

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation and interviews conducted during the abbreviated survey (NY00339079, NY00357873, NY00372568, NY00373759, NY00337630, NY00354632, NY00364043, NY00372738) from 4/21/25 to 4/23/25, the facility did not ensure that resident's dignity was maintained. 1) Specifically, residents on Apple unit were observed eating lunch and dinner meals on the unit hallways and residents waited a long time for assistance with eating; and 2) Certified Nurse Aide #20 referred to Resident #13 who required assistance with eating as a feeder and Activities Leader #4 referred to Resident #17 as a feeder in the presence of other residents. The findings are: The undated facility policy titled Resident Rights documented the purpose was to ensure the preservation of every resident's right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. 1) During multiple observations of meal services on 4/21/25 and 4/22/25, residents were observed eating lunch and dinner in the hallways of Apple unit. Residents were observed waiting extended time to be assisted with eating by staff due to a shortage of tray tables and shortage of staff available to assist residents with eating. On 4/21/25 at 11:55 AM, the lunch food truck was delivered to Apple unit/low side. During an interview of 4/21/25 at 12:00 PM Licensed Practical Nurse #3 stated residents were being served lunch and dinner meals in hallways due to two residents on Apple unit who tested positive for respiratory syncytial virus, resulting in closure of dining room. During an interview on 4/21/25 at 12:25 PM, Dietary Aide #19 stated the Apple unit dining room had been closed since 4/3/25, due to an outbreak on the unit. Residents had been served meals in the hallways since that time. They stated that lunch and dinner were served in hallways so staff could observe residents who could choke, and they could assist residents with eating. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and brief interview at 4/21/25 at 12:33 and 12:35 PM, Activities Leader #4 stated three residents in hallway were waiting for lunch trays to be served. They stated lunch trays were in food truck and could not be served due to lack of tray tables. The food truck was observed with door remaining open throughout lunch service. At 12:35 PM Activities Leader #4 provided a tray table for Resident #11, they placed the lunch tray on table, and then moved the lunch tray table approximately three feet away from resident. They stated lunch tray/table was placed away from Resident #11 because they required assistance with eating and had to wait until staff available to assist. Resident #11 was assisted with eating by certified nurse assistant #20 at 12:55 PM. The annual Minimum Data Set (a resident assessment too) dated 3/19/25 documented Resident #11 was dependent for eating. During an observation and brief interview on 4/21/25 at 12:36 PM, Licensed Practical Nurse #3 stated Resident #17 was waiting for a replacement tray due to initial tray spilling in food truck. Resident #17 was observed sitting at a table with another resident who had been served at 12:00 PM. Resident #17 was served replacement tray in hallway at 12:49 PM. During an observation and brief interview on 4/21/25 at 12:37 Certified Nurse Aide #20 stated they were not available to assist Resident #13 with eating due to assisting other residents with eating. Resident #13 had been served a tray at 12:00 PM and was not observed eating independently. The annual Minimum Data Set (a resident assessment tool) documented Resident #13 had severe cognitive impairment and required supervision or touching assistance during meals with helper providing verbal cues and/or touching/steadying and/or contact guard assistance as resident as completes activity and assistance provided throughout the activity or intermittently. During an observation on 4/21/25 at 1:00 PM, Resident #13 was again observed with an open uneaten tray on table. At 1:05 PM, Certified Nurse Aide #20 handed Resident #13 the ginger ale from tray. They did not assist or encourage resident to eat. Certified Nurse Aide #20 stated Resident #13 needs encouragement and assistance with eating and were aware Resident #13 had not eaten. They stated they had to complete assisting another resident and would then assist and provide encouragement for Resident #13 to complete lunch service. During observation on 4/21/25 at 12:11 PM and 1:07 PM Resident #14's lunch tray was observed unopened or set up at resident bedside. Lunch tray was observed delivered at 12:11 PM by activities leader #4. Resident lying in bed awake. At 1:07 PM, Resident #14 was assisted to sit up at bed side and tray set up completed by Certified Nurse Aide #21. The quarterly Minimum Data Set (a resident assessment tool) documented Resident #14 required setup or clean-up assistance requiring helper set up or clean up. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/21/25 at 4:51 PM Unit Manager Registered Nurse #1 stated Apple unit has been on quarantine for a couple of weeks. They stated quarantine means residents do not eat in unit dining room, do not participate in group activities or therapies and do not leave the unit. They stated that residents currently eat meals in the unit hallways due to residents having higher fall risk and that having residents in hallways allows staff to watch residents. They stated that the infection preventionist has requested that residents do not eat in the dining room during outbreak. They stated residents are in the hallway at mealtime for supervision reasons, not infection control reasons. Activities and rehabilitation department staff assist during meals due to unit having many residents who require assistance with eating. After a review of 4/21/25 staffing schedule 7 AM-3 PM shift with Unit Manager Registered Nurse #1, they stated there were two Certified Nurse Aides present on day shift (7:00 AM-3:00 PM) instead of the minimum of three. They stated that residents can wait a long time to receive assistance with eating when short-staffed. They stated the Director of Nursing and Administration were aware of heavy assistance required for residents on unit and need of more staff. 2) During an interview on 4/21/25 at 12:09 PM on the low side hallway, Activities Leader #4 referred to Resident #17 as a feeder while explaining that the resident was waiting for a nurse to assist with eating. This was in the presence of other residents and one family member. Activities Leader #4 stated they were not aware that the term feeder should not be used for residents who required assistance with eating. During an observation and interview on 4/21/25 at 12:37 PM on the low side hallway with other residents present, Certified Nurse Aide #20 referred to Resident #13 as a feeder during the lunch service when stating that they did not have time to assist Resident #13 at that time. They stated they were not aware they should not use the term feeder when addressing residents. 10 NYCRR 415.5 (d) (1)(i)

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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 observations, record review, and interviews conducted during an abbreviated (NY00372738, NY00373759) surveys, for 2 of 8 residents (#5 and #4) reviewed for activities of daily living, it was determined the facility did not ensure residents who were unable to carry out ADLs received the necessary services to maintain good nutrition and personal hygiene. Specifically: 1.) There was no documented evidence in the February 2025 Certified Nurse Aide Accountability Record that Resident #5 was toileted on the day or evening shift for 2/14/25 2.) Resident #4 was observed waiting over an hour for assistance with eating, after the meal was delivered. Findings include: 1) Resident # 5 had diagnoses including Non-Alzheimer's Dementia, Arthritis and Depression. The 2/9/25 Minimum Data Set, an assessment tool, documented the resident's cognition was intact and they required substantial to maximal assistance for toileting. The 2/1/25 Activities of Daily Living Care Plan documented Resident #5 required substantial to maximal assistance for bed mobility and was dependent for transfers with a two person assist. Interventions included to assist with toileting as necessary to promote continence; provide assistance with bed mobility and provide one to two person assist for turning and positioning. The February 2025 Certified Nurse Aide documentation had no documented evidence Resident #5 was toileted on the day and evening shift on 2/14/25. The Certified Nurse Aide documentation history detail for 2/14/25 documented resident was toileted on the night shift. During an interview on 4/22/25 at 2:44 PM, Certified Nurse Aide # 12 stated when they were dealing with rehab unit, the residents waited for up to 45 minutes to be toileted and was alert and would ask for more help. Certified Nurse Aide #12 stated the Birch unit ran smoothly on the evening shift when there were three certified nurse aides on the unit. When there were only two certified nurse aides it was less manageable. The residents were still taken care of, but they would wait longer periods of time. Certified Nurse Aide #12 stated the resident's family complained often about staffing and waiting long periods of time for the resident to be cared for. During an interview on 4/22/25 at 3:39 PM, Licensed Practical Nurse # 7 stated Resident #5 would be reminded often that while they were in rehab they required a mechanical lift for transfers and adult brief would be changed. They further stated when the resident progressed in rehab, they were able to put them on the toilet. Licensed Practical Nurse #7 stated the resident would ring the bell and wanted to go back to bed and they would need a second person for transfer, so they would have to wait until a second person would be available. This could take more than 15 minutes when a certified nurse aid was providing care to another resident. During an interview on 4/23/25 at 10:18 AM, the Director of Rehab stated the 2/6/25 physical therapy note documented the resident required moderate assist of 2 to do a stand pivot transfer from bed to wheelchair. The Director of Rehab stated Resident #5 was able to transfer to toilet on 2/14/25 with a 2 person assist. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) Resident #4 had diagnoses including seizures, diabetes and dysphagia The annual Minimum Data Set (an assessment tool) dated 2/21/25 documented the resident was rarely understood and was dependent on staff for all activities of daily living. The resident was always incontinent of bladder and bowel and was seen by the wound care team for deep tissue injury of the right medial heel. The resident was fully dependent on staff for feeding. The care plan for activities of daily living dated 3/20/24 documented interventions included tray set up and staff to feed and assist with completion of meal. The Certified Nurse Aide care record for the month of April 2025 documented for 23 days, only nine days had documentation of meal amounts for breakfast, eight days for lunch and 16 days for dinner. All other days were left blank. During an observation on 4/21/25 at 11:55 AM trays were delivered on the Apple unit low side. At 12:34 PM Resident #4's lunch tray was put in their room. At 12:57 PM Resident #4's lunch tray was at the bedside and the resident had not been fed by staff. At 1:15 PM Resident #4 was fed by Certified Nurse Aide #20. During an interview on 4/23/25 at 12:43 PM, Certified Nurse Aide #20 stated when there were only two Certified Nurse Aides the showers could run into lunch time. As soon as showers were finished, the priority was feeding the residents. They stated there were a lot of residents who needed to be fed and other departments sometimes came to help but not always. The Certified Nurse Aide stated they did document meals, but when there was not enough staff, sometimes it was not done. During an interview on 4/21/25 at 5:15 PM, Registered Nurse Unit Manager #1 stated the Certified Nurse Aides could not complete all showers as scheduled but did at least three to four today. They stated there are a lot of residents who need to be feed and they had spoken to Director of Nursing and was told they were working on getting staff in here. 10NYCRR 415.12(a)(3)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** F684 Based on record review and interview during an abbreviated survey (NY 00372568) the facility did not ensure that residents received treatment and care in accordance with professional standards of practice for 1 out of 3 residents (Resident # 8) reviewed for medications. Specifically, Resident #8 had a seizure disorder, the immediate-use seizure medication was not transcribed from the Hospital Discharge Summary and not available when the resident had a seizure, resulting in the resident being transferred to the hospital for treatment. The findings are: The Policy and Procedure titled Medication Administration last revised 12/24, documented all medication entries in electronic medical record will require two nurses to review each order. Nurse reviewing the order must ensure the order is routed to the proper place. Resident #8 was admitted to the facility on [DATE] with diagnoses of seizure disorder, Lennox-Gastaut syndrome, unspecified intellectual disabilities. The Minimum Data Set (MDS) dated [DATE] documented the resident had moderately impaired cognition and was dependent on staff with toileting hygiene, toilet transfer, supervision with personal hygiene. The resident was always incontinent of bowel and bladder. The Hospital Discharge summary dated [DATE] documented the resident had known history of refractory symptomatic epilepsy and was prescribed anti-seizure medications including Diazepam, (a medication used for relief of an active seizure) 10mg/dose nasal spray 1 spray nasal once, may repeat once after at least 4 hours if needed. The Comprehensive Care Plan Seizure Disorder dated on 2/6/25, documented monitor for seizure activity, administer anticonvulsant medications as ordered by medical doctor, neurology consult as per medical doctor order. Physician admission orders dated 2/4/25 included: - Clonazepam 0.25 mg disintegrating tablet. Place 1 tablet (0.25 mg) by oral route every 12 hours for 14 days. - Valproic acid (as sodium salt) 250 mg/5 mL oral solution. Give 20 milliliters (1000 mg) by oral route 2 times per day. - Briviact 100 mg tablet. Give 1 tablet (100 mg) by oral route 2 times per day. - Epidiolex 100 mg/mL oral solution SIG: give 7.2 milliliters by oral route every 12 hours provided privately. - Onfi 20 mg tablet. Give 1 tablet (20 mg) by oral route 2 times per day. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician admission orders dated 2/5/25 included: - Aptiom 400 mg, Give 3 tablets once daily for 5 days - Aptiom 600 mg tablet. Give 2 tablets (1,200 mg) by oral route once daily. Review of the physician's admission orders did not include Diazepam nasal spray, as on the Hospital Discharge Summary, or any other as needed (PRN) medication for breakthrough seizures. A Nurses Progress Notes dated 2/12/25 documented Resident #8 experienced a seizure in the morning that continued from the first initial report 10 AM, until Emergency Medical Technicians and paramedics arrived approximately 30-40 minutes later. Unable to give any oral, scheduled medications due to seizure, nurse practitioner made aware. Diazepam nasal spray ordered to be given immediately. Physician's Notes dated 2/12/25 documented Resident #8 had focal seizures for over an hour, the resident's mother at bedside, the resident was unable to take oral medications and intramuscular, and nasal medication was not available. During an interview on 4/23/25 at 2:38 PM Registered Nurse #23 stated they did the medication reconciliation upon resident's admission with Nurse Practitioner #1 over the phone. The nurse stated they reviewed hospital discharge papers with nurse practitioner and every medication before entering them as an order in the computer. The nurse stated if some medication was not entered that meant nurse practitioner did not approve it. The nurse stated they did not remember exactly what happened and why Diazepam nasal spray was not ordered. During over the phone interview on 4/23/25 at 2:02PM Nurse Practitioner #1 stated that they reviewed Resident #8 medications with admission nurse, and they did not remember what medications, and if Diazepam nasal spray was reviewed. 10 NYCRR 415.12

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 record review and interviews during an abbreviated survey (NY00357873, NY00372738, NY00373759, NY00339079), the facility did not ensure sufficient nursing staffing to attain or maintain the well-being of each resident. Specifically, 1) upon review of the staffing schedule for multiple days and on all three shifts of staffing for each floor for February 2025, March 2025 and April 2025, the facility did not provide adequate staffing to meet the needs of the residents and were staffed below their minimum staffing levels on many occasions. 2) The findings are: The facility Staffing Plan dated 7/13/20 documented the nursing department will maintain sufficient nursing staff to meet the care needs of all residents. Nursing services are provided 24 hours a day, seven days a week. The Facility Assessment provided by the facility was last revised on 4/18/25. The last review by the Quality Assurance and Improvement Committee was on 1/30/25. The staffing plan documented a table describing the number of staff available to meet residents' needs, which listed the position of staff by title, as well as the number of full-time employees that hold those positions. The facility Staffing Plan- Minimum Staffing Guidelines documented on all units for the day shift there will be a minimum three Certified Nurse Aides, evening shift will be a minimum two- and one-half Certified Nurse Aides on all units and night shift will be a minimum one- and one-half Certified Nurse Aides. A review of the staffing schedules for February 2025 documented there were four occasions of staffing below three Certified Nurse Aides on the day shift (2/15,2/16,2/18,2/20), one occasion of staffing below two- and one-half Certified Nurse Aides on the evening shift (2/14,)and one occasion of staffing below one- and one-half Certified Nurse Aides below on the night shift (2/17). A review of the staffing schedules for March 2025 documented there were four occasions of staffing below three Certified Nurse Aides working on the day shift (March 8,9,25 and 27) one occasion of staffing below two and one half Certified Nurse Aides on the evening shift (3/8) and two occasions of staffing below one and one half Certified Nurse Aides on the night shift (3/28, 3/30). A review of the staffing schedules for April 1-23, 2025, documented there were five occasions staffing was below three Certified Nurse Aides on the day shift (4/12,4/13,4/14,4/20,4/21) and two occasions below 2.5 Certified Nurse Aides on the evening shift (4/5,4/8). During an interview on 4/21/25 at 12:03 PM, Certified Nurse Aide # 20 stated it was almost time for lunch and had one more resident to get out of bed with a Hoyer Lift. They stated they knew it would be done while meal trays were being delivered but must get more residents out of bed. Certified Nurse Aide #20 stated it is like this all the time, especially when there is only two Certified Nurse Aides on the unit. Two showers had been given already but more are on the schedule and will not be able to get it all done. They stated they had six heavy residents on their assignment, two requiring Hoyer lift for transferring to a chair. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/21/25 at 4:36 PM Certified Nurse Aide #18 stated it was very hard to get work done when the staffing is less than three Certified Nurse Aides on evenings. The meal trays arrive at 4:37 PM because it takes a long time to feed everyone. They stated there are so many residents to feed and no one from Administration helps with the problem. They stated they had two showers to do and a total of six are scheduled to be done on the evening shift. During an interview on 4/21/25 at 4:47 PM Registered Nurse Unit Manager#1 stated when there are two Certified Nurse Aides on the day shift, they are not able to complete all showers as scheduled. They have spoken to the Director of Nursing and was told they are working on getting staff. They stated lunch is served in the hallway for fall risk residents otherwise they will be in their rooms. They stated it is better to see the residents in hallway. During an interview on 4/22/25 at 2:44 PM The Staffing Coordinator stated having four Certified Nurse Aides on the day shift is goal, most of the time they will find three Certified Nurse Aides. If there are extra staff on the schedule will staff the Dementia unit first and then the Rehab unit because of the higher acuity. They stated they receive the minimum staffing numbers from the Administrator and strives to get the numbers at four. They use agencies and incentives for staff to cover the holes in the schedule. During an interview on 4/22/25 at 2:44 PM, Certified Nurse Aide # 12 stated staffing needs improvement. When somebody calls out there will only be one certified nurse aide on each side and you will have up to 15-20 residents each with only 2 aides when there should be 3. Certified Nurse Aide #12 stated the Birch unit would run smoothly on the evening shift when there are 3 certified nurse aides on the unit. When there are only 2 certified nurse aides it makes it less manageable. When they are dealing with rehab unit, the residents are waiting for 45 minutes to be toileted because they are more alert and will ask for more help. The residents were still taken care of, but they will wait longer periods of time. Certified Nurse Aide # 12 stated the resident's family complained often about staffing and waiting long periods of time for resident to be cared for. During an interview on 4/22/25 3:22 PM with Certified Nurse Aide #8 and Certified Nurse Aide # 11 stated the staffing was bad. The facility used to give them $150 every time they picked up weekend a shift and stopped providing it. Certified Nurse Aide #8 and Certified Nurse Aide # 11 stated when they were short staffed, they did not get provided care timely. They stated they saw more urinary tract infections because residents were not being changed as much, and wounds would break down more as a result of not providing timely incontinence care. Certified Nurse Aide #11 and Certified Nurse Aide # 8 stated staff were getting physically sick because they were working too much and they were often asked to stay on for an extra shift. Certified Nurse Aide #8 and Certified Nurse Aide # 11 stated when they were short staffed with only 2 certified nurse aides per unit, they would end up with 20 residents each. They stated when they had 2.5 scheduled for 3 PM to 11 PM, the third aide came in at 7 PM and they were not always sure that person would show up. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/22/25 at 3:49 PM, Certified Nurse Aide #13 stated that staffing was terrible. Certified Nurse Aide #13 stated they felt short staffed all the time. Certified Nurse Aide #13 stated for the day shift, it was a good day when they had 4 certified nurse aides, which would be 2 certified nurse aides per side of the unit. They had to deal with residents' behaviors so there was a lot to do when they had less than 4 certified nurse aides per unit on day shift. They stated they felt they could not always get things done when they were short staffed unless they had the right team meaning regular staff not agency staff. Certified Nurse Aide #13 stated if they were short staffed, they may ask the resident to postpone a shower to the next shift or the next day. During an interview on 4/22/25 at 3:24 PM the Director of Nursing stated they have tried incentive programs and bonuses for staff to improve staffing but there is a need for more staff to feed residents. They stated this has been discussed at their Quality and Performance Improvement meetings. During an interview on 4/23/25 at 3:39 PM the Administer stated they have been at the facility for a few weeks and is working on improving staff numbers and looking for new staff. 10NYCRR 415.13(a)(1)(i-iii)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2). Resident #12 had diagnoses Alzheimer's disease, dementia and depression. An Annual Minimum Data Set (MDS) dated [DATE] documented the resident had severely impaired cognition and was dependent on staff with all activities of daily living. A physician order dated 11/26/24 documented to administer Baclofen 5 milligrams give 0.5 tablet (2.5 milligrams) 2 times per day, every day at 10 AM and 6 PM. Nurse's Progress Notes dated 12/4/24 documented the resident's family member was concerned that Baclofen might be making the resident lethargic. Registered Nurse Unit Manager #1 spoke with Nurse Practitioner #1 and Baclofen 2.5 milligrams was changed to once daily from twice daily. A physician order dated 12/4/24 documented to administer Baclofen 5 milligrams, give 0.5 tablet (2.5 milligrams) once daily. A physician order dated 12/5/24 documented to administer Baclofen 5 milligrams, give 0.5 tablet (2.5 milligrams) once daily. The December 2024 Medication Administration Record documented the physician's orders dated 12/4/24 and 12/5/24 to administer Baclofen 5 milligrams tablet, 0.5 tablet (2.5 milligrams) by oral route once daily. Licensed Practical Nurse #22 documented the medication was given 12/6/24, 12/7/24 and 12/8/24 at 10 AM for both physician's orders dated 12/4/24 and 12/5/24 for a total of 5 milligrams daily instead of 2.5 milligrams daily. During an interview on 4/22/25 at 1:27 PM, Registered Nurse Unit Manager #1 stated the physician order for Baclofen was put in twice and it was a duplicate order. Registered Nurse Unit Manager #1 stated that on 12/4/25 they entered the order for Baclofen 2.5 milligrams once daily every day at 10 AM. They stated that the same order was entered on 12/5/24 by another nurse. Registered Nurse Unit Manager #1 stated when the nurse noticed this situation they should have discontinue the duplicate order, contact the physician and documented the conversation. Registered Nurse Unit Manager #1 stated they could not comment as to if the medication was actually given twice. During over the phone interview on 4/22/25 at 1:57 PM Licensed Practical Nurse # 22 stated they remembered the situation with Baclofen medication in December. Licensed Practical Nurse # 22 stated on 12/8/24 they met with the resident's family and the family asked the nurse why the resident still received Baclofen 5 milligrams instead of Baclofen 2.5 milligrams once a day. Licensed Practical Nurse # 22 stated that they replied to the resident's family stating they saw two orders of Baclofen 2.5 milligrams in Medication Administration Record on 12/4/24 and 12/5/24 to give and assumed the medication dosage was increased. The nurse stated that they followed the orders, and unfortunately, they did not question these orders or asked anybody. Licensed Practical Nurse #22 stated that they gave a double dose of Baclofen 2.5 milligrams at 10 AM for three days and signed as they administered this medication. (continued on next page)

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	335824	A. Building B. Wing	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Putnam Ridge	46 MT Ebo Road North Brewster, NY 10509

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/22/25 at 2:51 PM, Director of Nursing stated the nurse had to question any duplicate order, needed to clarify the order with the health care provider or any superior before administering the medication. They stated the administration of double dose was a medication error. 10 NYCRR 415.12 (m)(2) Based on observations, record review and interviews during the abbreviated surveys (NY00337630, NY00373759, NY00364043) conducted 4/21/25-4/23/25, the facility did not ensure residents were free from significant medication errors for two (2) of four (4) residents (Residents #15 and #12) reviewed for Drugs and Medications. Specifically, 1) during a medication administration observation, staff crushed, without a physician order and administered extended-release (Nifedipine ER 30 milligrams) medication to Resident #15 and signed for guaifenesin cough medicine but did not give the resident the medication. 2) Resident #12 had a duplicate order for Baclofen (muscle relaxant) and received twice the planned dosage for three days. The findings include: The facility policy Medication Administration revised 12/2024 documented it is the policy that all medications be administered in a safe and systematic way. Proper technique for crushed medications must be used; a physician order obtained, and crushable medication to be given per MD and Pharmacy. 1) Resident #15 had diagnoses including Alzheimer's disease, ataxia and hypertension. The Quarterly Minimum Data Set (assessment tool) dated 2/13/25 documented Resident #15 had severe cognitive impairment and needed supervision for meals. The physician orders dated 2/23/25 documented low sodium, cut up dental soft, thin liquids diet with Aspiration Precautions. Nifedipine ER 30 milligram tablet, extended release 24 hr; give one tablet by oral route once daily at 10 AM. The physician orders dated 4/20/25 documented Guaifenesin 100 milligrams/5 cc oral liquid; give five milliliters(100 milligrams) by oral route three times a day for ten days, ordered for 10 AM. During a medication observation on 4/22/25 at 10:32 AM on the Apple Unit with Licensed Practical Nurse #24 removed Nifedipine ER (Extended Release) 30 milligram tablet from the blister pack to a cup with other pills, crushed it and administered it to Resident #15 with applesauce on a teaspoon. A red and yellow sticker on the blister pack documented Do not crush. During the medication reconciliation with the physician orders, it was noted Guaifenesin cough syrup was not administered during the observation. The Medication Administration Record was reviewed and the time slot for ten am had Licensed Practical Nurse#24 initial indicating it was given at ten am. There was no documented evidence of a physician order to crush medications. During an interview on 4/22/25 at 11:50 AM, Licensed Practical Nurse #24 stated Resident #15 was supposed to get guaifenesin cough syrup but did not get it during the med pass because they overlooked it. They stated they did sign for it and should not have. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Licensed Practical Nurse #24 on 4/22/25 at 11:55 AM, the blister pack for the nifedipine 30 milligrams was observed with the Do Not Crush sticker. Licensed Practical Nurse #24 stated the medications had to be crushed as the resident could not swallow pills whole. They were not aware if there was an order to crush medications and stated they now see the warning sticker on the blister pack. They stated nifedipine extended release should not have been crushed. During an interview on 4/22/25 at 12:00 PM Registered Nurse Unit Manager #1 stated all meds that were crushed needed to have a physician order. Nifedipine Extended Release should not have been crushed, as it would cause the resident to get a bigger dose all at once. The nurse should have called the physician to get the form change to something the resident could swallow or a form that was not extended release. Registered Nurse Unit Manager #1 stated nurses should not be signing for medication they did not give and signatures were to be done after the medications were given.

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F 0811 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are assessed for appropriateness for a feeding assistant program, receive services as per their plan of care, and feeding assistants are trained and supervised. Based on observation, interview and record review conducted during the Recertification Survey and Abbreviated Surveys (NY00354632, NY00357873, NY00337630, NY00372738, NY00372568, NY00373759, NY00364043, NY00339079) 4/21/25 to 4/23/25, the facility did not ensure one of five residents (Resident #11) were fed by staff members who completed a State-approved training course to assist residents in eating or drinking as required by regulations. Specifically, the facility was not able to provide documentation that Unit Assistants successfully completed a State approved training course for one Resident Assistants (Unit Assistant #26) observed feeding Resident #11 during a lunch meal. The findings are: Resident #11 diagnoses included Alzheimer's disease, Dementia and abnormal weight loss. The 4/21/25 Physician Order documented regular diet, blenderized texture, thin liquids consistency, aspiration precautions. The 3/19/25 Minimum Data Set documented Resident # 11 had severe cognitive impairment, was dependent on staff for all activities of daily living including eating and on a mechanically altered diet (requiring change in texture of food/liquids). The 12/27/21 revised Activities Daily Living Care Plan documented interventions to include tray set up, staff feeds and assists to completion of meals. The facility job description for Unit Assistant dated 4/2021 documented the Unit Assistant assists on the nursing unit with functions that do not require certification. Listed under task #18 is feeding During an observation on 4/23/25 at 12:57 PM Unit Assistant #26 was observed sitting next to Resident #11 and feeding them puree food. During an interview on 4/23/25 at 12:57pm on Apple Unit Assistant #26 stated they had been doing the job for three years and one of the tasks was to feed the residents. They stated they had training in feeding by someone in the therapy department and were not aware of a New York State training for feeding residents. During an interview on 4/22/25 at 3:15 PM the Director of Human Resources stated the Unit Assistants do not provide direct care. The Unit Assistants will go on outside appointments with residents, provide water pitchers, make beds and feed residents. They feed residents because they have been trained at the facility on feeding as far as they know the Unit Assistants have not taken a state test for feeding residents. During an interview on 4/23/25 at 2:44 PM the Director of Nursing stated there was no eight hour course provided or completed by any of the paid feeding assistants. They stated they did not know there was a change and had been doing it this way for a few years now. They stated they will look into getting the program because the Unit Assistants do a great job and need them until they can improve regular staffing numbers. (continued on next page)

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F 0811 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10 NY CRR415.14

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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 and interviews conducted during the abbreviated survey (NY00339079, NY00357873, NY00372568, NY00373759, NY00337630, NY00354632, NY00364043, NY00372738) conducted 4/21/25 to 4/23/25, the facility did not ensure infection control prevention practices were maintained to prevent the development and transmission of communicable diseases and infection and did not ensure there was a system for preventing, identifying, reporting, investigating, and controlling infection and communicable disease for all residents. Specifically, 1) facility staff were observed entering and exiting a contact and droplet isolation room (Resident #14) without donning and doffing personal protective equipment or performing hand hygiene. 2) Licensed Practical Nurse #3 was observed with their thumb entering the milk carton for Resident # 9 and Activities Leader #4 was observed with their thumb entering the top of milk carton for Resident #17. 3) Resident #18 was positive for respiratory syncytial virus and was observed walking up and down hallways of Apple unit without a mask during lunch and throughout the afternoon on 4/21/25 and 4/22/25 while residents were eating in the hallways. Resident #18 also was observed sitting in close proximity of other residents during dinner service on 4/21/25. The findings are: The policy titled Infection Prevention and Control, reviewed 10/24 documented the facility will provide appropriate types, sizes and supplies of personal protective equipment. Facility shall train staff and establish protocols for selecting, donning and doffing appropriate personal protective equipment and demonstrate competency during resident care. 1) Resident #14's diagnoses included respiratory syncytial virus, unspecified dementia and chronic pulmonary obstructive disease. The Quarterly Minimum Data Set (a resident assessment tool) dated 4/11/25 documented that Resident #14 had moderate cognitive impairment, required set up/clean up assistance with eating and partial to moderate assistance from staff with showering/bathing and toileting. A physician order dated 4/21/2025 documented contact/standard isolation precautions for respiratory syncytial virus. Resident #14's care plan updated 2/11/25 titled at risk for alteration in respiratory status due to atelectasis /scarring documented a goal of resident's respiratory status will not impact on resident's activities of daily living. Interventions included notify physician of any respiratory changes for interventions and keep head of bed elevated at all times. During an observation and interview on 4/21/25 at 12:11 PM Activities Leader #4 was observed delivering lunch tray to Resident #14. Contact and droplet precaution signs were posted outside door. Activities Leader #4 did not don/doff personal protective equipment, perform hand hygiene, change mask, wear face shield/ eye covering or close door when entering / exiting room. At 12:21 PM, Activities Leader #4 was again observed re-entering the room, placed trash into garbage container and entered bathroom without donning/doffing personal protective equipment, changing mask, wearing face shield/goggles, performing hand hygiene or closing door to room upon exit. During an interview at 12:22 PM, they stated they did not follow the contact and droplet precaution guidelines posted outside the door to room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 4/21/25 at 12:25 PM and 12:47 PM, Dietary Aide #19 was observed entering Resident #3 and #14's room, delivering juices during lunch service. Dietary Aide #19 did not don or doff gown, gloves, wear face shield/goggles or perform hand hygiene prior to entering and exiting the room. They did not replace facemask they wore prior to entering room. During an interview with Dietary Aide #19, they stated they did not don/doff personal protective equipment or perform hand hygiene when entering and exiting room of Residents #3 and #14. They stated they did not observe the signs at room entrance indicating contact and droplet precautions and were not aware which resident was on precautions or if it was both residents. During an observation and interview on 4/21/25 at 1:07 PM Certified Nurse Aide #21 was observed entering the room of Resident #14, assisted the resident to sit up at side of bed and performed lunch tray set up without donning/doffing personal protective equipment or performing hand hygiene prior to entering/exiting room. During a brief interview with Certified Nurse Aide #21 upon exiting room, they stated they did not don/doff personal protective equipment or perform hand hygiene prior to leaving the room or change mask. They stated that did not notice the signs or personal protective equipment outside the room. They stated they had utilized hand sanitizer at the end of hallway upon entering unit and did not perform hand hygiene prior to leaving room. During an observation and interview on 4/22/25 at 10:20 AM and 10:35 AM, Nurse Practitioner #1 was observed entering the room of Residents #3 and #14. Nurse Practitioner #1 was wearing a face mask which was not changed prior to entering / exiting room, and they did not don or doff personal protective equipment or perform hand hygiene prior to entering room, exiting room or between residents. They were observed using their stethoscope and physically touching Residents #3 and 14 without donning gloves or performing hand hygiene. Nurse Practitioner #1 stated they were aware that Resident #14 tested positive for respiratory syncytial virus prior to entering the room. They were unable to explain why they did not don/doff personal protective equipment required for contact and droplet precautions or perform hand hygiene before, after and in between physical contact with the two residents present in the room. They stated they were not specifically aware of personal protective equipment requirements for residents on contact and/or droplet precautions. They stated they usually follow precautions and could not explain why they did not on this occasion. During an interview on 4/22/25 at 11:04 AM, Infection Preventionist Registered Nurse stated contact and droplet precautions required personal protective equipment use by all staff members entering a room where a resident was positive for respiratory syncytial virus, including interactions with a non-infected resident in the same room. They stated the residents positive for respiratory syncytial virus were placed on contact and droplet precautions to reinforce to staff the importance of masking and personal protective equipment use. 2) During an observation and interview on 4/21/25 at 12:09 PM, Activities Leader #4 was observed setting up lunch for Resident #16. Activities leader #4 placed their thumb into the top of the milk container. They stated they should not have placed thumb deep inside the opening of milk carton. During an observation and brief interview on 4/21/25 at 12:44 PM, Licensed Practical Nurse #3 was observed opening milk carton without gloves or performing hand hygiene before assisting with tray set up for Resident #9. Licensed Practical Nurse #3's right thumb was observed entering the top of milk carton when opening. During a brief interview Licensed Practical Nurse #3 stated their right thumb did not enter top of milk carton and stated hand hygiene was performed before observation. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3) On 4/21/25 Resident #18, who was positive for respiratory syncytial virus, was observed walking up and down the hallway without a mask on during lunch and dinner services and also sitting in close proximity of other residents during dinner meal service in hallway. Staff did not provide encouragement for Resident #18 to wear a mask and did not attempt to redirect. During an interview on 4/21/25 at 4:51 PM, Unit Manager Registered Nurse #1 stated that Resident #18 was positive for Respiratory Syncytial Virus. They stated that Resident #18 walked up and down the unit hallway continuously and they tried unsuccessfully to have Resident #18 wear a mask. The resident was routinely reoriented not to walk into other residents rooms. 10 NYCRR415.19