

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335824	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/07/2025
NAME OF PROVIDER OR SUPPLIER  Putnam Ridge		STREET ADDRESS, CITY, STATE, ZIP CODE  46 MT Ebo Road North Brewster, NY 10509	

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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>Based on record review and interviews conducted during an abbreviated survey (NY00384916), the facility did not ensure that comfortable and safe temperature levels were maintained in all areas during a heat emergency, when the air conditioning unit on one unit (Dogwood), located on the first floor of the building, was not functional on 06/23/2025. Specifically, the facility could not provide documentation that temperatures in resident rooms were adequate or comfortable during the breakdown of the air-conditioning system from 06/23/2025 to 06/24/2025. The air-conditioning was restored to residents' rooms on 06/24/2025 at 3:00 PM. The Administrator stated that they did not check resident room temperatures, as this was not part of the facility's policy. Since the hallway temperatures on Dogwood were within regulation, the air-conditioning issue was not reported as a heat emergency.</p> <p>The findings include:</p> <p>The facility policy titled Heat Emergency states that, during all seasons, a comfortable temperature must be maintained throughout the occupied areas of the facility, consistent with Department of Health regulatory requirements. It is the responsibility of the Maintenance Department to monitor and maintain temperatures within a desired range of 71&amp;deg;F to 81&amp;deg;F. The Director of Building Services is responsible for monitoring ambient air temperatures during periods of high heat and humidity and for documenting temperature readings on a Temperature Log Sheet. The Administrator must review the temperature log daily during periods of high heat. The Maintenance Department is supported in these efforts by all other departments, who are responsible for reporting any changes in the air-conditioning system that could place residents in jeopardy. Resident rooms are to be routinely checked to ensure proper air-conditioning function. The Administrator or designee must notify the local New York State Department of Health in the event of an actual or anticipated heat-related emergency.</p> <p>On 06/23/2025, hallway temperatures of the four (Apple, Birch, Cedar, and Dogwood) facility units ranged from 71&amp;deg;F to 78.3&amp;deg;F - within regulation.</p> <p>On 06/24/2025, hallway temperatures ranged from 71&amp;deg;F to 78.6&amp;deg;F - within regulation.</p> <p>On 06/25/2025, hallway temperatures ranged from 71&amp;deg;F to 74.5&amp;deg;F - within regulation.</p> <p>On 06/26/2025, resident room temperatures ranged from 71&amp;deg;F to 78.3&amp;deg;F - within regulation.</p> <p>There was no documented evidence that resident room temperatures were checked during the breakdown of the air-conditioning system from 06/23/2025 to 06/24/2025 on the Dogwood Unit.</p> <p>(continued on next page)</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  Facility ID: 335824	If continuation sheet Page 1 of 2

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 06/26/2025 at 1:20 PM, during a telephone interview with the Director of Nursing, they stated they were not aware of any air-conditioning issues and had not received complaints from residents or families regarding uncomfortable room temperatures. However, they stated they would follow up by checking resident room temperatures and calling back once the information was gathered.</p> <p>In a follow-up call on 06/26/2025 at 3:18 PM, the Director of Nursing stated that Resident #1's spouse did complain on 06/23/2025 about the unit (Dogwood) being too hot, but a grievance report was not completed because an air-conditioning unit was immediately installed in the dining area, and the issue was considered resolved.</p> <p>On 06/26/2025 at 2:38 PM, during a telephone interview with the Administrator, they stated that there were no issues with air-conditioning in the facility and that no complaints had been received from residents or families.</p> <p>On 06/30/2025 at 9:30 AM, a message was left for the complainant requesting a return call.</p> <p>On 06/30/2025 at 9:31 AM, during a telephone interview with the Director of Maintenance, they stated they did not check resident room temperatures but only monitored hallway temperatures for the four units on 06/23/2025, 06/24/2025, and 06/25/2025.</p> <p>On 06/30/2025 at 1:35 PM, during a telephone interview with the Administrator, they stated the air-conditioning failure was not reported to the New York State Department of Health because Dogwood hallway temperatures remained within regulation: 74.8-75&amp;deg;F at 9 AM, 74.7-76.1&amp;deg;F at 11 AM, 75.1-77.3&amp;deg;F at 1 PM, 76.3-77.5&amp;deg;F at 3 PM, and 77.9-78.3&amp;deg;F at 4:30 PM. The Administrator stated that they had only recently joined the facility (three months prior), and they intended to revise the Heat Emergency policy to include checking every resident room temperature.</p> <p>On 06/30/2025 at 2:50 PM, during a telephone interview with the Director of Nursing they stated that Resident #1's spouse expressed discomfort with the room temperature on 06/23/2025, although the resident was reportedly fine. The Director stated they visited Dogwood twice that day and did not personally feel the unit was hot. Nursing staff did not check resident room temperatures, and the Director was unaware that maintenance had also not checked them. Maintenance installed an air-conditioning unit in the Dogwood dining area and fans in the hallway but not in resident rooms. Full air-conditioning service in the Dogwood Unit was restored around 3 PM on 06/24/2025. The Director stated that no residents experienced heat-related symptoms between 06/23/2025 to 06/30/2025.</p> <p>415.5(h)(2)</p>		