

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 09/29/2025
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 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review during the recertification and abbreviated surveys (#2582376) the facility did not ensure resident choice related to provider of health care services was met for one (1) of one (1) resident investigated for choices. Specifically, Certified Nurse Aide #23 continued to provide care for Resident #75 after their representative communicated a preference of not having Certified Nurse Aide #23 provide care to Resident #75. The findings include: Resident #75 had diagnoses that included but were not limited to dementia, anxiety, and major depressive disorder. The grievance dated 07/11/2025 documented a request was made on 12/14/2024 that Certified Nurse Aide #23 not be assigned to care for Resident #75. On 01/12/2025, Certified Nurse Aide #23 was observed by Resident #75's son providing cares to Resident #75. The Significant Change Minimum Data Set, dated [DATE] documented Resident #75 had severely impaired cognition, no behaviors, and was dependent on staff assistance for all activities of daily living. During an interview on 09/29/2025 at 10:43 AM, the Director of Social Work stated Resident #75's son communicated that they did not want Certified Nurse Aide #23 providing cares to their mother on 12/14/2024. They stated residents and their representatives had the right to determine who provided them with care. They stated they were not certain why Certified Nurse Aide #23 provided care to Resident #75 on 01/12/2025. During an interview on 09/29/2025 at 11:12 AM, the Assistant Director of Nursing stated the unit manager would know how the certified nurse aide was made aware that they should not provide cares to Resident #75. They stated Certified Nurse Aide #23 should not have been assigned to, or provided cares to, Resident #75 on 01/12/2025. During an interview on 09/29/2025 at 11:54 AM, Registered Nurse Unit Manager #11 stated Resident #75's son requested that Certified Nurse Aide #23 not care for their mother. They stated when communicated to them, they informed the Director of Nursing, Staffing Coordinator, the floor nurses, and Certified Nurse Aide #23. They stated Certified Nurse Aide #23 should not have provided care for Resident #75 on 01/12/2025 since the request was made on 12/14/2024. They stated they were not working on 01/12/2025 and were unaware why Certified Nurse Aide #23 took the assignment. 10NYCRR 415.5(b) (1-3)</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
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on observation, interview, and record review conducted during the recertification and abbreviated surveys (#2601270), the facility did not ensure all alleged violations of abuse were reported immediately, but not later than 2 hours to the state survey agency for one (1) of two (2) residents reviewed for abuse (Resident #164). Specifically, on the morning of 08/26/2025 Resident #164 was observed with a bruise to the right eye and bruise to the right arm that was not reported to the state agency until 08/26/2025 at 11:05 PM. The findings include: The policy and procedure titled Abuse Prevention and Reporting dated 01/09/2001, last revised 09/2024 documented if the events that cause the reasonable suspicion (but no later than 2 hours after forming suspicion). Resident #164 had diagnoses including Cerebral Infarction, Pulmonary Embolism, and an unspecified intellectual Disability. The Quarterly Minimum Data Set (A resident assessment tool) dated 06/20/2025 documented the resident had severe cognitive impairment. And was dependent with all activities of daily living. The Accident and Incident Report dated 08/26/2025 at 11:00 AM documented discoloration to the right eye, Nurse Practitioner notified. Interventions ice and x-rays. The Nurse Practitioner progress note dated 08/26/2025 (late entry) at 1:11 PM documented right forehead ecchymosis, swelling to the right orbit. Assessment and Plan status Post Fall- sent to emergency room for evaluation. The incident Report documented it had not been submitted until 8/26/2025 at 11:05 PM The reportable incident written by the Director of Nursing on 09/01/2025 summarized on 8/26/25 at 10:30 AM Licensed Practical Nurse #10 entered Resident #164's room and noted bruising to the right eye and notified Licensed Practical Nurse # 8, who assumed the resident had accidentally hit the side of her face on the side rail and intervened by padding the siderail, called the Nurse Practitioner and initiated an Accident and Incident Report. On 8/26/25 at 11:07 AM the Nurse Practitioner assessed the resident and noted increased swelling around the eye and a bruise on the right arm and subsequently concluded the resident's injuries were consistent with a fall. The Assistant Director of Nursing was made aware and began an investigation. During an interview on 09/29/2025 at 11:30 AM the Director of Nursing stated they came to the building after a concern regarding injuries sustained by Resident #164. They stated an investigation started prior to their arrival at the facility and statements were being taken. They stated after Certified Nurse Aide #7 provided a statement on 08/26/2025 at 11:00PM that they provided care alone, a report was called to the Health Department on 08/26/2025 at 11:05PM. They Stated the bruises as identified by the Nurse Practitioner could be considered injuries of unknown origin. They stated they knew injuries of unknown origin should be reported to the Health Department within two (2) hours. During an interview on 09/29/2025 at 12:19 PM the Administrator stated they were aware of the event of 08/26/2025 but were not involved in the investigation. They stated all injuries of unknown origin should be reported to the Health Department within 2 hours. During an interview on 09/29/2025 at 12:53 PM the Assistant Director of Nursing stated they recalled the event of 8/26/25. They stated they evaluated the resident after the Nurse Practitioner assessed the resident. They stated they started an investigation into how the injury of unknown origin may have occurred and notified the Director of Nursing and the Administrator around 2 PM. They stated they were unaware of when the incident was reported to the Health Department. 10 NYCRR 415.4(b)(2)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>Based on record review and interview during the recertification survey and an abbreviated survey (#2601270 and 2577313), the facility did not ensure development and/or implementation of comprehensive person-centered care plans that included measurable objectives and timeframes to meet resident needs for two (2) of four (4) residents (#164 and #116) reviewed for accidents, three (3) of five (5) residents (#20, #44, and #63) reviewed for activities, one (1) of two (2) residents (#41) reviewed for positioning and one (1) of three (3) residents (#142) reviewed for restraints. Specifically, 1. implementation of two person staff assistance for transfer/bed mobility was not provided for Resident #164 as per care plan 2. there was no documented evidence of a care plan to address the use/release schedule of a lap/seat belt for Resident # 142 and 3. the use of hand rolls was not implemented as per physician order and there was no documented evidence of a care plan to address the physician ordered use of rolled gauze in the hands and knee abductor roll when in the wheelchair for Resident #41. Additionally: there was no documented evidence of a care plan to address activities for Resident #63, #20 and #44 and every one-hour safety checks were not consistently implemented as per care plan for Resident #116. The findings include:</p> <p>The January 2025 policy and procedure titled, Care Plans-Comprehensive documented individualized comprehensive care plan that include measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological need is developed for each resident.</p> <p>1) Resident #164 was admitted to the facility with diagnosis including but not limited to history of cerebral infarction (ischemic stroke), pulmonary embolism (a blood clot to the lungs), and unspecified intellectual disability.</p> <p>The 06/20/2025 Quarterly Minimum Data Set (a resident assessment tool) documented Resident #164 had severely impaired cognition and required total assistance for activities of daily living.</p> <p>The August 2025 care plan titled Activities of Daily Living documented Resident #164 was dependent with bed mobility, transfers and required two (2) persons for assistance.</p> <p>The August 2025 Certified Nurse Aide Kardex and Tasks documented Resident #164 required 2 person staff assist for bed mobility and transfers.</p> <p>The 09/01/2025 Incident Summary written by Director of Nursing documented that on 08/26/2025 at approximately 6:30AM Resident #164 was noted with bruising to the right eye, bruise to the right elbow, and a small laceration to the right forehead. An investigation into the incident found Certified Nurse Aide # 7 provided care with no assistance to the resident at 11PM on Monday 08/25/2025. During that care, Resident #164 had a fall from bed and suffered an injury from the fall. Certified Nurse Aide #7 placed the resident back in bed with a mechanical lift.</p> <p>During an interview on 09/29/2025 11:30 AM the Director of Nursing stated Certified Nurse Aide # 7 performed one (1) staff assist during cares for Resident #164 who required two (2) staff assist with bed mobility.</p> <p>2) Resident #142 was admitted to the facility with diagnoses including but not limited to Dementia, fracture of the femur, and repeated falls.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The 06/14/2025 physician order documented velcro alarm seatbelt in the wheelchair, release every two (2) hours to provide cares and release at meals. Monitor residents' ability to self-release alarmed seat belt on command daily.</p> <p>There was no documented evidence in the care plan to address the use/release schedule of a lap/seat belt or any other restraint.</p> <p>The 09/15/2025 Minimum Data Set documented, Resident #142 had severe cognitive impairment, was dependent for sit to stand and transfers, and did not use physical restraints or alarms.</p> <p>During an observation on 09/22/2025 at 12:40 PM Resident # 142 was wearing the lap/seat belt at lunch. During an observation on same day at 3:20 PM Resident #142 was wearing the lap/seat belt in the day room. When this surveyor asked Resident #142 to remove the lap/seat belt three (3) separate times, Resident #142 was unable to complete the request.</p> <p>During an observation on 09/24/2025 at 1:18 PM and 3:35 PM Resident #142 was in a wheelchair in the day room with a lap/seat belt in place.</p> <p>During an interview on 09/24/2025 at 3:35 PM Certified Nurse Aide #18 was asked to check the Kardex for information on procedure regarding the lap/seat belt. Certified Nurse Aide #18 stated there is no information about the lap/seat belt and if the direction is not in the Kardex the staff would not be aware of how to care for the residents.</p> <p>During an interview on 09/24/2025 at 3:35 pm Licensed Practical Nurse #3 stated they were not aware of the order to release the lap/seat belt every two (2) hours. They stated it is probably in place due to Resident #142 being a fall risk. Licensed Practical Nurse #3 stated Resident #142 can take the lap/seat belt off but had not witnessed them take it off upon request. During an interview on 09/24/2025 at 12:58 PM Registered Nurse Unit Manager #11 stated they did not see anything in the care plan to address the lap/seat belt and that they thought it was in place for a previous hip fracture.</p> <p>3) Resident #41 had diagnoses including but not limited to Alzheimer's disease, contracture of the knee, and muscle weakness.</p> <p>The 08/13/2025 Minimum Data Set documented, Resident #41 had severe cognitive impairment and was dependent for all activities of daily living.</p> <p>The 06/12/2025 physician order documented knee abductor roll when in bed and when in wheelchair, and right and left-hand protector/roll of gauze at all times, remove for frequent skin checks and hygiene.</p> <p>There was no documented evidence in the comprehensive care plan to address the use of rolled gauze in the hands or knee abductor roll when in the wheelchair.</p> <p>During an observation on 09/23/2024 at 9:48 AM Resident #41 was in the day room in a wheelchair with right foot crossed over the left foot, leaning to the right. No devices (rolled gauze) were present in either hand.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 09/24/2025 at 1:22 PM Resident #41 was in the day room with no devices (rolled gauze) present in hands.</p> <p>During an interview on 09/25/2025 at 4:36 PM Occupational Therapist #21 stated Resident #41 should have rolled gauze in both hands for contractures and the abductor roll between legs. They stated nursing should enter the recommendations made by therapy into the care plans.</p> <p>During an interview on 09/29/2025 at 12:58 PM Registered Nurse Unit Manager #11 stated the treatment administration record included the directive for application of the gauze rolls by the medication nurse. Upon review of the care plan Registered Nurse Unit Manager #11 stated they could not locate the documentation in the care plan to address the use of the gauze rolls or the knee abductor. They stated the care plan must not have gotten transferred over from the previous electronic medical record to the current medical record.</p> <p>10 NYCRR415.11(c)(1)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide activities to meet all resident's needs.</p> <p>(continued on next page)</p>

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observation, interview, and record review conducted during the recertification and abbreviated surveys (#2583366), the facility did not ensure that activities of preference and interest were available and designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community for one (1) of one (1) resident (Resident #20) reviewed for behavior-emotional care and one (1) of three (3) residents reviewed for restraints (Resident #7). Specifically, 1) Resident #20 was observed on multiple occasions wandering in the hallways of the unit and not participating in activities; 2) Resident #7 missed an activity that was held off the unit because the activities staff was unable to transfer the resident from an enclosed frame walker to a wheelchair. The findings include 1) Resident #20 had diagnoses that included, but were not limited to, dementia, schizophrenia, and depression. The 05/25/2025 care plan titled Behavior Symptoms Wandering documented exhibits wandering as evidenced by entering peer rooms, wanders aimlessly. Provide pleasant diversions included redirection, activities, food, and conversation. The 07/18/2025 Annual Minimum Data Set documented severe cognitive impairment, and religion and music activities were very important. The 07/30/2025 Interdisciplinary Care Plan Meeting note documented Resident #7 enjoys singing, going outside for fresh air and walking around the unit. The care plan titled Behavior Management Program with an 08/04/2025 revision date documented requires ongoing redirection, monitoring, and structured activities to alter behavior. There was no documented evidence of a care plan to address activities for Resident #20. During an observation on 09/22/2025 at 11:17 AM, Resident #20 was sitting in the unit common area with other residents. Music was playing and no activities were taking place. During an observation on 09/23/2025 9:44 AM, Resident #20 was observed walking down the hallway unsupervised. An activity was in progress, but Resident #20 was not participating. During an observation on 09/24/2025 at 9:34 AM, Resident #20 was wandering in the unit hallway. At 9:41 AM, Resident #20 took a seat in the unit common area by the nurse's station. There was an activity going on inside the common room, but Resident #20 was not involved with the activity. During an interview on 09/24/25 at 1:35 PM, the Director of Activities stated activities care plans were their responsibility. They stated the facility transferred to a new electronic medical record in June, and some care plans were not in the current system. They stated Resident #20 did not have a current activity care plan so their preferences would need to be communicated verbally amongst staff. During an observation on 09/25/2025 at 10:29 AM Resident #20 was ambulating on the unit in the common area. Resident #20 attempted to walk out of the area, but staff redirected them to sit in a chair. During an observation on 09/26/2025 at 10:01 AM an activity was going on in the common area on the unit, Resident #20 was not participating. Resident #20 was wandering unsupervised in the hallway checking doors, not engaged by staff, and playing with the window by an exit door. Resident #20 walked back toward the nurse's station and went behind the nurse's desk. Resident #20 was then redirected by staff to the activity in the common area and assisted into a chair by the window. Resident #20 did not engage in the activity. 2) Resident #7 had diagnoses that included but were not limited to Alzheimer's Disease, anxiety, and depression. The 08/26/2025 Significant Change Minimum Data Set documented severe cognitive impairment, music, outdoor, animal, group, and religious activities were moderately important. The 09/10/2025 care plan titled Resident deemed a Significant Change dated 09/10/2025 documented enjoys music, talking, and being outdoors. Will participate in on unit programs with encouragement and participate in off unit events with transport assistance. Invite resident to events and provide assist with transport. During an observation on 09/25/2025 at 10:52 AM, Resident #7 was invited to a coffee social by an activities staff member and accepted the invitation. The activities staff member stated they would have to transfer them to another chair to attend and would return. Resident #7 waited in the common area, resting in an enclosed frame walker with their eyes closed. At 11:01AM, Resident #7 was still sitting in the unit common area in an enclosed frame walker. At 11:16AM, Resident #7 remained on the unit in an enclosed frame walker. During an interview on 09/29/2025 12:41 PM, Registered Nurse Unit Manager #11 stated Resident #7 may attend activities off the unit, but they go off the unit in a transport chair. They stated recreation handles transport when taking the residents off the unit. During an interview on 09/29/2025 at 2:46 PM, the Director of Recreation stated Resident #7 was not at the coffee social on 09/25/2025 but does attend off unit activities on occasion. They stated since the introduction of the enclosed frame walker, Resident #7's attendance at off unit activities had decreased. They stated activities staff could not transfer residents from walkers to wheelchairs. They stated</p>		

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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. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview conducted during the Recertification and Abbreviated Survey (#2601270, and #2577313), it was determined the facility failed to ensure each resident received adequate supervision and/or assistance to prevent accidents for two (2) of four (4) residents (Resident #164 and #116) reviewed for accidents. Specifically, 1) on the morning of 08/26/2025, Resident #164 was noticed in bed with a contusion (bruise) to their right face, right elbow, and a forehead laceration (skin wound). The facility investigation determined Resident #164 who required two (2) staff assist for bed mobility and/or transfers was provided one (1) staff assist which resulted in an 08/25/2025 fall from bed. Subsequently, Resident #164 was transferred to the hospital on [DATE] and was diagnosed with an acute (sudden) intertrochanteric (thigh) right femur (thigh bone) fracture (broken bone), and 2) Resident #116 was not provided with one (1) hour safety checks to prevent falls as per the plan of care which resulted in the resident falling out of their wheelchair unwitnessed by staff on 08/27/2025. This resulted in actual harm for Resident #164 that was not Immediate Jeopardy. The findings include: 1) Resident #164 was admitted to the facility with diagnoses including but not limited to history of cerebral infarction (ischemic stroke), pulmonary embolism (a blood clot to the lungs), and unspecified intellectual disability. The 06/20/2025 Quarterly Minimum Data Set (a resident assessment tool) documented Resident #164 had severely impaired cognition and required total assistance for activities of daily living. The August 2025 care plan titled Activities of Daily Living documented Resident #164 was dependent with bed mobility, transfers and required two (2) persons for assistance. The August 2025 Certified Nurse Aide Kardex and Tasks documented Resident #164 required two (2) person staff assist for bed mobility and transfers. The 08/26/2025 at 10:30 AM Accident/Incident Investigation documented Licensed Practical Nurse #10 went into Resident #164's room to administer medications. Resident #164 was found in bed with bruising and swelling to the right eye and surrounding area. Medical Doctor/Nurse Practitioner assessment and orders: x-ray of the face, nose, shoulder and hip on the right side. The 08/26/2025 at 11:07 PM progress note, written by Nurse Practitioner #1, documented they were asked to see the resident who had a swollen/ bruised right eye. Resident #164 was found to have a bruise on the forehead, laceration on the right nose, evidence of a nosebleed with dried blood in the left nostril and bruising to the right upper arm. The assessment and plan documented status post fall, resident is on Elixquis and after initially ordering x-rays, the resident will be sent to the hospital emergency room. The 08/26/2025 hospital emergency room note documented on 08/26/2025 the resident presented as a level 2 trauma after a presumed fall. A computed tomography scan (a non-invasive imaging procedure) showed an acute intertrochanteric right femur fracture. The 09/01/2025 Incident Summary written by Director of Nursing, documented that on 08/26/2025 at approximately 6:30 AM, Resident #164 was noted with bruising to the right eye, bruise to the right elbow, and a small laceration to the right forehead. The resident is noncommunicative and could not provide a statement as to what caused the bruise. An investigation into the incident found the 11:00 PM to 7:00 AM Certified Nurse Aide # 7 provided care with no assistance to the resident at 11:00 PM on Monday 08/25/2025. During that care, Resident #164 had a fall from bed and suffered an injury from the fall. Certified Nurse Aide #7 placed the resident back in bed with a mechanical lift. During an interview on 09/24/2025 at 3:00 PM, Licensed Practical Nurse #9 stated they were the nurse on 08/26/2025 during the 11:00 PM to 7:00 AM shift and were working with two (2) Certified Nurse Aides. They stated at approximately 11:00 PM, Certified Nurse Aide #7 was in Resident #164's room attending to their care. They stated around midnight; they noticed Certified Nurse Aide #7 came out of the room to obtain a mechanical lift and brought it to Resident #164's room. They stated Certified Nurse Aide #6 came from another unit, entered Resident #164's room and after a few minutes, left Resident #164's room. They stated in the morning; they went into Resident #164's room and noticed a small area around Resident #164's right eye. They stated, they thought it was a scratch and did not know if it was new. During an interview on 09/29/2025 at 10:44 AM, Licensed Practical Nurse Supervisor #8 stated on the morning of 08/26/2025 they were in morning report when they received a text from Licensed Practical Nurse #10 (the medication nurse) about bruising on Resident #164. They stated when they went to the unit and noted bruising and edema around the resident's eye. They stated at the time they felt the resident may have hit the side of their head on the side rail. They stated Nurse Practitioner #1 was notified and gave orders for staff to apply ice and obtain x-rays. They stated when Nurse Practitioner #1 assessed Resident #164 they ordered the resident be sent</p>		

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<p>F 0741</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents.</p> <p>(continued on next page)</p>		

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 09/29/2025
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.			
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<p>F 0741</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review conducted during the recertification and abbreviated surveys (#2583366) the facility did not ensure sufficient staff to provide services to maintain the highest practicable physical, mental and psychosocial well-being as per individualized care plan for one (1) of one (1) resident (Resident #20) reviewed for behavior and emotional care. Specifically, ongoing monitoring/supervision and thirty-minute checks were not consistently implemented for Resident #20 with a history of wandering and defecating/urinating in inappropriate places. The findings include:Resident #20 had diagnoses that included but were not limited to dementia, schizophrenia, and depression. A 07//09/2025 Grievance documented a family member observed Resident #20 stabilizing themselves by putting their hand on top of Resident #126's head and they were fumbling with the drawstrings on their pants. Resident #20's private area was close to Resident #126's face. No staff were supervising Resident #20 as they were tending to other residents. The family member had to call for staff assistance. The 07/18/2025 Annual Minimum Data Set documented severely impaired cognition, supervision for ambulation and maximal staff assistance for toileting. The care plan titled Behavior Management Program last revised 08/04/2025 documented requires ongoing redirection, monitoring, and structured activities to alter behavior, lock installed on closet to divert resident from taking others' clothing; examples of behaviors taking other resident clothing, urinating and defecating in inappropriate places. The care plan titled Behavior-Wandering last revised 08/04/2025 documented exhibits wandering as evidenced by entering peer rooms, wanders aimlessly. Staff redirection, provide pleasant diversions including activities, food, conversation, television, and books. 30-minute safety checks were initiated 07/07/2025. The care plan titled Socially Inappropriate Behaviors-Urinating and Defecating last revised 08/04/2025 documented monitor every half hour by staff, monitor for pacing behavior, and offer toileting. The 08/22/2025-09/23/2025 Thirty Minute Checks revealed no documentation for entire shifts on 27 of 30 dates and no documentation for all shifts on three (3) of 30 dates. During an observation on 09/23/2025 at 10:32 AM, Resident #20 was observed walking down the unit hallway and wandered into the room of a resident on contact precautions for clostridium difficile. Resident #20 proceeded to wander around the room, opening doors, touching furniture, windows and other items. During observation on 09/23/2025 at 2:10 PM while unsupervised Resident #20 leaned against the post/column outside the Apple unit dining room. Resident #20 had their hands on the waistband of their pants. Resident #20 pulled down their pants, squatted slightly and began to expel feces. During an interview on 09/24/2025 at 11:11 AM, Resident #44's spouse stated they have observed Resident #20 urinating and defecating in inappropriate places like the floor, in resident rooms, and in their closet. During an interview on 09/25/2025 at 10:04AM with the complainant they stated Resident #20 continues to roam the hallways unsupervised. They wander in and out of rooms all the time. On 07/09/2025 they observed Resident #126 sitting in a wheelchair in the common area, Resident #20 had their hand on Resident #126's head and was fumbling with their drawstring on their pants. They stated their private area was covered but in proximity to Resident #126's face. The complainant stated they did not believe Resident #20 was being sexually inappropriate, they just needed to go to the bathroom. They stated there were no staff monitoring and they had to call for assistance. They stated the facility should have been monitoring Resident #20. During an observation on 09/25/2025 at 11:18AM, Resident #20 ambulated down the unit hallway, attempted to open a door in the hallway but was unable, and continued to the window at the end of the hallway. Resident #20 then wandered into room [ROOM NUMBER], walked around in the room, came out, and headed back up the hallway independently. No staff supervision or redirection was observed. During an observation on 09/26/2025 starting at 08:30AM, Resident #20 was observed in their room eating breakfast independently. Their tray was collected at 08:50AM. Resident #20 wandered in their room and then left the room and was in the hallway, heading toward room [ROOM NUMBER]. Resident #20's pants were visibly soiled, their brief was bulging and appeared low, and their sweatshirt was on backwards. At 9:29 AM Certified Nurse Aide # was coming out of another room and directed Resident #20 back to their room and left. Resident #20 came out of their room again and was entering room [ROOM NUMBER]. Certified Nurse Aide # in the hallway saw Resident #20 and escorted them out of room [ROOM NUMBER] and back to their room for cares at 9:34 AM. During an interview on 09/26/2025 at 10:32 AM, Certified Nurse Aide #12 stated that Resident #20 does exhibit behaviors including going to the bathroom everywhere in inappropriate places and wandering into other residents' rooms</p>		