

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

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 07/13/2026
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)		
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility did not ensure that a resident was free from physical restraints for purposes of discipline or convenience that are not required to treat the resident's medical symptoms and did not ensure the evaluation of the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This was evident for one resident investigated for Restraints out of three total sampled residents. Specifically, Resident # 1 had a diagnosis of dementia with documented behaviors in nursing progress notes and a history of falls. On 11/27/2025 at approximately 5:55 AM Resident #1 was placed in a wheelchair in the hallway of their unit with a bed sheet wrapped around their waist and the bedsheet was tied securely to the back of the wheelchair. Findings include: The facility policy titled Restraints dated 09/16/2025 documented A physical restraint will only be used in necessitating a resident's/patient safety and the of others. Physical restraints are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's/ patient's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Resident #1 was admitted to the facility on [DATE] with diagnoses that include but are not limited to dementia, anxiety, and muscle weakness. An admission minimum data set (an assessment tool) dated 11/17/2025 documented Resident#1 had a brief interview of mental status score of one, indicating severe cognitive impairment. Resident #1 had no behaviors present. Resident #1 had no impairment on the upper and lower extremities and required set-up/clean up assistance with eating, maximum assist with toileting, and moderate assist with bed mobility and transfers. Resident # 1 had an indwelling catheter and was always continent of bowel. Review of physician orders dated 11/2025 indicated there were no orders in place for a physical restraint. The facility's document titled, State Report dated 11/27/2025 documented on 11/27/2025 at approximately 5:55 AM, during rounds Registered Nurse #1 came to the unit and witnessed the resident sitting in the wheelchair with a blanket wrapped around their waist and wheelchair. Registered Nurse #1 removed the blanket, checked the body noting no redness and/or pain, brought Resident #1 to their room and then to their bed per Resident # 1's request. During an interview with Registered Nurse #1 on 06/05/2026 at 11:20 AM they stated they walked on to the unit on 11/27/2025 and observed Resident #1 tied to the wheelchair by a bed sheet. Resident #1 was in the hallway near room [ROOM NUMBER] and Licensed Practical Nurse #1 was nearby doing their medication pass. The other aides were at the other end of the hallway. Registered Nurse #1 stated the first thing they did was untie the bed sheet. The bed sheet was wrapped around the stomach and tied around the back of the wheelchair; this looked like a restraint. They removed the bed sheet and spoke with Licensed Practical Nurse #1 who stated they did not know anything about it. Certified Nurse Aide #1 who had been assigned to Resident #1 was on (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

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the opposite side assisting the other aide with getting other residents out of bed. Registered Nurse #1 stated that the provider and Registered Nursing Supervisor# 1 assessed the resident and found no bruising, no excoriation, no redness or pain. Registered Nurse #1 stated Certified Nurse Aide #1 stated to them that Resident #1 kept trying to get up so they tried to keep Resident #1 safe. Registered Nurse #1 stated that they informed Certified Nurse Aide #1 even though Resident #1 had behaviors at the time tying them to the wheelchair was not acceptable. Certified Nurse Aide #1 stated to Registered Nurse #1, Well Resident #1 keeps trying to get up and they are trying to stop them from getting up. Registered Nurse #1 reported the incident to Registered Nurse Supervisor #1 on 11/27/2025 that Resident #1 was found on the unit tied to their wheelchair by a bed sheet. Registered Nurse Supervisor #1 then called Certified Nurse Aide #1 on the unit and informed them that restraints are not allowed. During an interview on 06/05/2026 at 2:51 PM with Certified Nurse Aide #1 they stated Resident #1 had behaviors where they would attempt to get out of bed, and they were a high fall risk. Certified Nurse aide #1 stated that at the time of the incident they were assigned to Resident #1 and they wrapped Resident #1 around with a bed sheet to bind them to the chair; so that the resident would not fall. Certified Nurse Aide #1 stated they were thankful that Resident #1 did not fall that shift, and it was the only time they ever binded Resident #1 to the wheelchair, but they did this to keep Resident #1 safe and prevent them from falling. Certified Nurse Aide #1 stated they received training on resident rights and restraints after the incident. During an interview on 06/09/2026 at 11:00 AM with Director of Nursing #2 they stated they received the initial report on 11/27/2025 that Resident #1 was tied up. Director of Nursing #2 stated that after the incident they interviewed Certified Nurse Aide #1 who had told them that Resident #1 had an episode of bowel incontinence and Certified Nurse Aide #1 brought the resident into their room to provide care. Afterwards, Resident #1 pushed past the staff and was naked in the hallway. Director of Nursing #2 stated that when they interviewed Certified Nurse Aide #1, they were told that the bed sheet was wrapped around Resident #1's waist for dignity purposes so they were not exposed in the hallway. Director of Nursing #2 stated they gathered statements from staff and the Administrator took over the investigation and conducted interviews with staff. Previously in the facility the director of nursing would be a part of the investigation process and summary to identify the root cause analysis, but this did not occur with this investigation. During a telephone interview with the Administrator on 07/13/2026 at 1:32 PM they stated that they were informed about the incident with Resident #1 on 11/27/2025, the same day it occurred. Administrator stated they investigated immediately to rule out abuse. The administrator stated that they were involved in the investigation by conducting interviews. Director of Nursing #2 collected the statements from the staff. The Administrator stated that when they interviewed Certified Nurse Aide #1, they informed them that they secured the bed sheet around Resident #1 with the intention to keep them safe and prevent them from falling. The Administrator informed Certified Nurse Aide #1 that this was not acceptable and considered a restraint. Certified Nurse Aide #1 was suspended pending investigation and reeducated on restraints and abuse. The Administrator stated that when they conducted the investigation, they interviewed the nursing supervisor, licensed practical nurse, and certified nurse aides. The social worker interviewed 11 residents that Certified Nurse Aide #1 had on their assignment, and they all stated that Certified Nurse Aide #1 never abused them and provided good care. At the conclusion of the facility's investigation the abuse was not verified because the resident was not injured and had a psychiatric consultation. The Administrator stated Certified Nurse Aide #1 did not intend to harm Resident #1. 10 NYCRR 415.3(d)(1)(vii)		