STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335839	A. Building B. Wing	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Affinity Skilled Living and Rehabilitation Center	305 Locust Avenue Oakdale, NY 11769

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observations, interviews and reviews, the facility failed to ensure that each resident received treatment and care based on their comprehensive assessment in accordance with professional standards of practice. This was identified for one (1) (Resident #180) of one (1) resident reviewed for physical restraints. Specifically, Resident #180 with severely impaired cognition had a diagnosis of down syndrome and a facility acquired stage III pressure ulcer (a deep, full-thickness wound extending through the skin into subcutaneous fat, but not exposing muscle, tendon, or bone) to their right buttock. Resident #180 was unable to verbalize their needs and required total assistance from two (2) staff members with all aspects of care except for eating. On 03/12/2026 at 4:20 AM and 5:06 AM, Resident #180 was observed sleeping in a dark room while seated upright in a tilt-in-space wheelchair (a specialized wheelchair that tilts the user backward for redistributing pressure from the buttocks to the back to prevent pressure sores). Resident #180 was physically restrained with an upper body Posey belt (a harness-like belt that wraps the resident's trunk to keep the resident in an upright position) without a physician's order. At 6:07 AM, Resident #180 was observed to be awake and was still seated in the tilt-in-space wheelchair with the Posey belt restraint in place. Interviews with facility staff and review of the video surveillance revealed that the resident was not turned, positioned, or provided care for more than seven (7) hours. The resident's plan of care required them to be turned and positioned every two (2) to four (4) hours and their brief checked and changed every two (2) to four (4) hours. This resulted in actual harm and likelihood of serious injury, harm, impairment or death to Resident #180 that is Immediate Jeopardy. The finding is:The facility policy titled Restraints last reviewed 02/02/2026 documented the primary focus is to ensure the safety and well-being of residents while minimizing the use of restraints to the greatest extent possible. Informed consent must be obtained from the resident or their legally authorized representative before implementing any restraint. The healthcare team must provide a clear explanation of the reasons for restraint use, potential risks and benefits, and alternatives. Residents under restraint must be closely monitored, and the effectiveness of restraint interventions must be regularly evaluated. Thorough and accurate documentation is essential for all aspects of restraint use, including initial assessment, informed consent, ongoing monitoring and evaluations. The facility policy titled Activities of Daily Living last reviewed 02/02/2026 documented residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. Appropriate care and services will be provided for residents who are unable to carry out activities of daily living independently, in accordance with the plan of care including elimination (toileting).The facility policy titled Incontinence last reviewed 02/02/2026 documented the staff and physician will summarize an individual's continence status. Incontinence care should be individualized at night to maintain comfort and skin integrity.The facility policy titled Quality of Care last reviewed 02/02/2026 documented the facility shall ensure each resident receives the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the resident's comprehensive assessment, plan of care, physicians' orders, and applicable federal and state regulations. Quality of care and services are necessary to maintain or improve resident health consistent with professional standards. Avoidable decline is the (continued on next page)

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	deterioration resulting from failure to provide appropriate evaluation, monitoring, treatment, or interventions. Residents are monitored for changes in condition including skin conditions. Changes are evaluated promptly and interventions implemented.The undated facility policy titled Pressure Ulcer Prevention Management and Treatment Program, documented the charge nurse would update the certified nursing assistant accountability record sheet when a pressure ulcer is identified this should include: a turning and positioning schedule; out of bed schedule; toileting schedule; and adaptive/assistive devices. The incontinence care every two (2) to four (4) hours and as needed following each incontinent episode. Turning and positioning as per individual's care plan. When in a chair, if the pressure ulcer site can be relieved, the resident can sit for a limited time per an established positioning schedule. If pressure on the ulcer site can be relieved, the resident can sit for a limited time per an established positioning schedule. Use of seat cushions that redistribute pressure when applicable.Resident #180 was admitted with diagnoses that included down syndrome (genetic condition caused by an extra copy of chromosome 21 leading to intellectual disability, developmental delays, and distinct physical features and low muscle tone), pressure ulcer right buttock stage III, and bipolar disorder (chronic mental health condition characterized by intense alternating mood swings). The Quarterly Minimum Data Set (a resident assessment tool) dated 12/13/2025 documented a Brief Interview for Mental Status score was not completed as the resident was never understood and had severely impaired long and short term memory. The Minimum Data Set documented Resident #180 used a wheelchair and was dependent on two (2)staff members for all aspects of care. Resident #180 was always incontinent of bowel and bladder and was at risk for developing pressure ulcers and did not have pressure ulcers.A Comprehensive Care Plan dated 01/06/2026 and last revised 03/08/2026, documented right buttock stage III pressure ulcer, interventions included turn and position every two (2) to- four (4) hours.A Comprehensive Care Plan dated 09/10/2025 and last reviewed 12/15/2025, documented Resident #180 requires restraint alternative use secondary to inability to sit up on their own and maintain proper body alignment. Interventions included quarterly review and evaluation of use and for possible reduction. Inform family representative of benefits and risks associated with restraint use.A Comprehensive Care Plan dated 09/09/2025 and last revised 03/09/2026 documented Resident #180 has behavior symptoms to crawl out of bed onto the floor as a method of locomotion. Interventions included redirecting the resident during behavioral episodes and assessing behaviors for causative factors. A Comprehensive Care Plan dated 09/09/2025 and last revised 01/14/2026 documented Resident #180 requires assistance with Activities of Daily Living. Intervention included assistance of two (2) staff members with all aspects of care except for eating. A Restraint Alternative vs Restraint Determination assessment form dated 09/08/2025 documented Resident #180 was evaluated for a restraint alternative or restraint for the following reasons: tend to lean forward, and poor trunk control. The medical symptoms were leans forward and impulsive behavior. The device (name of device not indicated) is appropriate to maintain resident safety due to impulsive movements. The assessment form did not indicate the team's decision whether the device was a restraint alternative or a restraint. The form did not indicate the resident representative was notified. A physician's order dated 09/09/2025 documented out of bed to personal tilt-in-space wheelchair.A review of the physician's orders revealed no documented evidence of orders for the use of the Posey belt restraint, monitoring or skin check instructions related to the use of the restrictive device.A review of the medical record from 12/01/2025-03/09/2026 revealed multiple nursing progress notes indicating Resident #180 was found crawling out of bed on the floor and into the hallway. Resident #180 was redirected back to their room and was placed in their wheelchair.During an observation on 03/10/2026 at 06:51 AM, Resident #180 was observed in a dark room sitting upright on a roho cushion (a specialized cushion for pressure relief) in a tilt in space wheelchair. The resident was strapped to their wheelchair with a Posey restraint. Resident #180 was making loud incoherent random sounds. During an observation on 03/12/2026 at 04:20 AM, Resident #180 was in their room in the dark, sleeping in their wheelchair while sitting upright on a roho cushion. The resident was restrained with (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	a Posey belt that was attached to the wheelchair with their hands secured under the Posey belt.During an observation on 03/12/2026 at 05:06 AM, Resident #180 was in their room in the dark, sleeping in their wheelchair while sitting upright on a roho cushion. The resident was restrained with a Posey belt that was attached to the wheelchair with their hands secured under the Posey belt.During an observation on 03/12/2026 at 06:07 AM, Resident #180 was sitting on a roho cushion in their wheelchair. The resident was awake. Resident #180 was able to remove their hands from under the Posey belt; however, they could not release the Posey belt on request. During an interview on 03/12/2026 at 06 :09 AM, Certified Nursing Assistant #1 (assigned to Resident #180) stated Resident #180 was usually in bed when they come in for their 11:00 PM to 07:00 AM shift; however, last night they came in at 03:00 PM and were assigned to Resident #180 for both shifts. Certified Nursing Assistant #1 stated they put Resident #180 into bed at 11:00 PM on 03/11/2026 and took the resident out of bed to the wheelchair about a half an hour ago (05:39 AM). Certified Nursing Assistant #1 they were not aware that Resident #180 was in the wheelchair at 04:20 AM and 05:06 AM and reiterated that they transferred Resident #180 into the wheelchair half an hour ago, without assistance from anyone. The surveillance video footage was reviewed on 03/12/2026, with the facility administrator and revealed that Certified Nursing Assistant #1 did not go into Resident #180's room from 10:26 PM on 03/11/2026 until 5:43 AM 03/12/2026. Certified Nursing Assistant #1 was in the resident's room for nine (9) minutes from 05:43 PM to 05:52 AM. The medication nurse, Licensed Practical Nurse # 1, was observed going into the resident's room for less than a minute at 02:55 AM and 05:30 AM. During an interview on 03/12/2026 at 09:52 AM, Licensed Practical Nurse #1 stated Resident #180 was in their wheelchair sleeping when they started their shift on 03/11/2026 at 11:00 PM. During their rounds they went into the resident's room on 03/12/2026 at 02:55 AM and Resident #180 was asleep in their wheelchair. Licensed Practical Nurse #1 stated they returned to the resident's room at 05:30 AM to administer the medications and observed Resident #180 sleeping in the wheelchair. Licensed Practical Nurse #1 stated the wheelchair Posey belt was restraining and did not know if skin checks were needed when utilizing a restraining device. During an interview on 03/12/2026 at 02:14 PM, Wound Care Registered Nurse #1 stated Resident #180 developed a stage II pressure ulcer to the coccyx, at the facility on 01/01/2026. The stage II pressure ulcer was healed on 01/13/2026. The resident developed a new unstageable pressure ulcer to their right buttock on 01/06/2026. Wound Care Registered Nurse #1 stated Resident #180 utilizes a roho cushion on their wheelchair for the prevention of pressure ulcers. Wound Care Registered Nurse #1 stated Resident #180's pressure ulcer was unavoidable because of the resident's risk factors such as incontinence, agitation, and frequent movements. Resident #180 should be turned and positioned every two (2) to four (4) hours when in bed. The Certified Nursing Assistant should shift the resident's weight and reposition every two (2) to (4) hours when the resident is seated in the wheelchair. Their brief should be checked and changed every two (2) to four (4) hours. Wound Care Registered Nurse #1 stated the existing pressure ulcer would deteriorate if the resident was left seated in the wheelchair all night long and not repositioned or changed. Wound Care Registered Nurse #1 stated the facility's electronic medical record did not allow the certified nursing assistants to document provision of turning and positioning every two (2) to four (4) hours and there was no way of knowing if the residents were turned and positioned as per the plan of care. Wound Care Registered Nurse #1 stated they believed the Director of Nursing Services was aware that the electronic medical record system was not working correctly. During a re-interview on 03/13/2026 at 9:36 AM, Licensed Practical Nurse #1 stated they did not speak to Certified Nursing Assistant #1 about Resident #180 being left in the chair all night because Certified Nursing Assistant #1 had their job, and they had their own job. Licensed Practical Nurse #1 stated they were busy as they were the only medication nurse on the 11:00 PM-7:00 AM shift for the entire unit. They regularly see Resident #180 at night sleeping in a wheelchair. Resident #180 did better in the wheelchair because when they are placed in the bed they would get out and crawl around the room and the unit. Licensed Practical Nurse #1 stated they have their own assignment to follow and (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	are not responsible for monitoring the certified nursing assistants to see if the certified nursing assistants are providing resident care.During an interview on 03/13/2026 at 9:43 AM, the Director of Nursing Services stated the staff should have provided incontinence and toileting care and turning and positioning as per Resident #180's plan of care. Resident #180 should not have been left in their wheelchair all night long. This created a likelihood for wound deterioration and development of new wounds. The Director of Nursing Services stated that the harness-like belt is a Posey assistive device and was not considered a restraint even though the resident was unable to open the Posey assistive device on request. The Director of Nursing Services stated that the Posey assistive device did not require a physician's order. During an interview on 03/13/2026 on12:08 PM, the Administrator stated Resident #180 should not have been left in the wheelchair all night and that the staff must follow the resident's plan of care including brief change every two (2) to four (4) hours and turning and positioning every two (2) to four (4) hours. The Administrator stated they were not clinical and expected clinical staff to follow the resident's plan of care and document provision of care. During an interview on 03/13/2026 at 12:38 PM, the Medical Director stated when a resident is not provided with incontinence care and is not turned and positioned every two (2) to four (4) hours, they can develop pressure ulcers or current pressure ulcers could deteriorate and develop infection if the resident is left sitting in urine and feces. Resident #180 should have been placed in bed and not left in the wheelchair for a long time. The Medical Director stated that the nurse should have asked for an order for the Posey restraint.10 New York Codes, Rules, and Regulations 415.12

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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 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observations, record reviews, and interviews, the facility failed to ensure that each resident with pressure ulcers received necessary treatment and services consistent with professional standards of practice to promote healing, prevent infection, and prevent new ulcers from developing. This was identified for one (1) (Resident #180) of five (5) residents reviewed for Pressure Ulcers. Specifically, Resident #180 was admitted to the facility with no pressure ulcers and was assessed to be at risk for developing pressure ulcers, was incontinent of bowel and bladder, and used a Posey restraint (device to limit patient movements) in their wheelchair at night. On 01/01/2026: Developed a Stage 2 (a partial-thickness skin loss) ulcer on the coccyx (small triangular bone at the bottom of the spine). On 01/06/2026: Developed an unstageable ulcer (full-thickness tissue loss where the wound bed is fully covered by dead tissue) on the right buttock. On 01/20/2026: Right buttock wound required debridement (the medical removal of dead, damaged, or infected tissue from a wound to promote healing and prevent infection) and was classified as a Stage 3 pressure ulcer (a full thickness wound extending through the skin layers into the subcutaneous fat, resulting in deep, crater like injury). There was no documented evidence that Resident #180 had their brief checked and changed or was turned and positioned every 2-4 hours to offload the pressure areas as per their care plan. This failure, involving lack of incontinence care and care plan implementation, resulted in actual harm to Resident #180 that is not Immediate Jeopardy. The findings were:The undated facility policy titled Pressure Ulcer Prevention Management and Treatment Program, documented when a pressure ulcer is identified the certified nursing assistant accountability record sheet should include a turning and positioning schedule, out of bed schedule as per individual care plan, toileting schedule every 2-4 hours and as needed, and any adaptive/assistive devices. When in a chair, if the pressure ulcer site can be relieved, the resident can sit [in the chair] for a limited time as per the established turning and positioning schedule. The facility policy titled Quality of Care last reviewed 02/02/2026, documented avoidable decline is the deterioration resulting from failure to provide appropriate evaluation, monitoring, treatment, or interventions. Residents are monitored for changes in condition including skin conditions. Resident #180 was admitted with diagnoses that included down syndrome (genetic condition leading to intellectual disability, developmental delays, and distinct physical features and low muscle tone) and bipolar disorder (chronic mental health condition characterized by intense alternating mood swings). The Quarterly Minimum Data Set (a resident assessment tool) dated 12/13/2025, documented the resident had severely impaired long and short term memory problems. The Quarterly Minimum Data Set assessment documented Resident #180 was dependent on staff for all aspects of activities of daily living care. Resident #180 was always incontinent of bowel and bladder and was at risk for developing pressure ulcers. The resident used a wheelchair as the mobility device. The comprehensive care plan dated 09/08/2025 last revised on 12/15/2025 titled altered health maintenance-skin integrity: impaired cognition, bowel and bladder incontinence, fragile skin and skin desensitization to pain/pressure documented interventions included monitoring skin integrity every shift, providing good skin care after each episode of incontinence, changing brief every 2-4 hours, turning and positioning every 2-4 hours in bed, repositioning in out of bed seating (wheelchair) every two (2) hours, and avoiding positioning directly on trochanter (bony prominence on the upper part of the thighbone).The nursing progress note dated 01/01/2026 documented a new open area to the coccyx was noted with a Stage 2 pressure ulcer measuring 0.5 centimeter in length, 0.5 centimeter in width and 0.1 centimeter in depth. The peri wound area (area surrounding the wound bed) had slight erythema (redness). The physician order dated 01/02/2026 documented to apply Venelex ointment (topical wound treatment) twice a day to the coccyx. Cleanse open area with normal saline, pat dry followed by Venelex ointment with dry clean dressing twice a day and as needed. A Comprehensive Care Plan dated 01/06/2026 documented the resident had a right buttock unstageable pressure injury. The comprehensive care plan was updated on 02/07/2026 and (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	documented that the unstageable pressure ulcer to the right buttock was changed to Stage 3 pressure ulcer on 01/20/2026, and documented interventions including monitoring skin integrity daily, provide pressure reducing cushion and pressure reducing/relieving mattress, provide rest periods and turn and position every 2-4 hours. The wound care note dated 01/06/2026, written by a nurse practitioner, documented they were called to evaluate the sacrum (buttock area) for a report of skin impairment to the area. Risk factors included physical deconditioning, weakness, down syndrome, air mattress and Roho cushion (specialized cushion for pressure relief) contraindicated due to fall risk, specialty wheelchair use, incontinence, and resident being resistive with hands on care. The physical examination indicated a coccyx Stage 2 pressure injury. Treatment as ordered [01/02/2026]. The assessment included a new unstageable pressure injury to the right lower buttock with recommendations to cleanse the right buttock wound with normal saline followed by Santyl (enzymatic debriding agent) every day and as needed. Due to comorbidities and risk factors, and contraindications with offloading measures, ulcers were unavoidable. An untitled investigation report for Resident #180's pressure ulcer dated 01/07/2026, documented the pressure ulcers were a result of Resident #180's behavior of combativeness with care, and the constant need to be repositioned in the wheelchair. Resident #180 was incontinent of bowel and bladder, and staff had difficulty performing wound care secondary to the resident's behaviors. The wound care note dated 01/13/2026 documented coccyx pressure ulcer healed. Conservative sharp debridement was completed for the right lower buttock unstageable wound at the bedside. The resident tolerated the procedure well. Recommendations to continue Santyl and dry clean dressing once daily and as needed. Wound care note dated 01/20/2026 documented the right lower buttock pressure injury was assessed to be a Stage 3 pressure ulcer. Recommendations were to continue Santyl, and dry clean dressing daily and as needed. A review of the medical record from 12/01/2025 - 03/09/2026 indicated multiple nursing progress notes documenting that Resident #180 was found crawling out of bed on the floor and into the hallway. Resident #180 was redirected back to their room and was placed in their wheelchair.The Certified Nursing Assistant Accountability instructions dated 09/08/2025 (resident care instruction provided to certified nursing assistants) documented Resident #180 required two (2) person assistance for bed mobility, dressing, grooming, bathing, and transferring. It further documented Resident #180 was to have their brief changed every 2-4 hours and as needed, and to be turned and positioned every 2-4 hours, female Certified Nursing Assistants only. There was no documented evidence that the resident was turned and positioned every 2-4 hours or that the brief check and change was performed every 2-4 hours. During an observation on 03/10/2026 at 6:51 AM, Resident #180 was observed in a dark room sitting upright on a Roho cushion in a tilt-in-space wheelchair. The resident was strapped to their wheelchair with a Posey restraint. Resident #180 was making loud incoherent random sounds. During an observation on 03/12/2026 at 4:20 AM, Resident #180 was in their room in the dark, sleeping in their wheelchair while sitting upright on a Roho cushion. The resident was restrained with a Posey belt that was attached to the wheelchair with their hands secured under the Posey belt.During an observation on 03/12/2026 at 5:06 AM, Resident #180 was in their room in the dark, sleeping in their wheelchair while sitting upright on a Roho cushion. The resident was restrained with a Posey belt that was attached to the wheelchair with their hands secured under the Posey belt.During an observation on 03/12/2026 at 6:07 AM, Resident #180 was sitting on a Roho cushion in their wheelchair. The resident was awake. Resident #180 was able to remove their hands from under the Posey belt; however, they could not release the Posey belt upon request. During an interview on 03/12/2026 at 6 :09 AM, the assigned Certified Nursing Assistant #1 stated Resident #180 was usually in bed when they come in for their 11:00 PM to 7:00 AM shift; however, last night they came in at 3:00 PM and were assigned to Resident #180 for both shifts. Certified Nursing Assistant #1 stated they put Resident #180 into bed at 11:00 PM on 03/11/2026 and took the resident out of bed to the wheelchair about a half an hour ago (5:39 AM). Certified Nursing Assistant #1 stated they were not aware that Resident #180 was in the wheelchair at 4:20 AM and (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	5:06 AM and reiterated that they transferred Resident #180 into the wheelchair half an hour ago without assistance from anyone. The video surveillance footage was reviewed with the facility administrator on 03/12/2026 and revealed that Certified Nursing Assistant #1 did not go into Resident #180's room from 10:26 PM on 03/11/2026 until 5:43 AM 03/12/2026. Certified Nursing Assistant #1 was in the resident's room on 03/12/2026 for nine (9) minutes from 5:43 AM to 05:52 AM. The medication nurse, Licensed Practical Nurse #1, was observed going into the resident's room for less than one (1) minute on 03/12/2026 at 2:55 AM and 5:30 AM. During an interview on 03/12/2026 at 9:52 AM, Licensed Practical Nurse #1 stated Resident #180 was in their wheelchair sleeping when they started their shift on 03/11/2026 at 11:00 PM. On 03/12/2026, they went into Resident #180's room at 2:55 AM and the resident was asleep in their wheelchair. Licensed Practical Nurse #1 stated they returned to the resident's room at 5:30 AM to administer the medications and again observed Resident #180 sleeping in the wheelchair. During an interview on 03/12/2026 at 2:14 PM, Wound Care Registered Nurse #1 stated the resident uses a Roho cushion on their wheelchair for prevention of pressure ulcer development. The plan of care requires turning/positioning in bed and shifting weight/repositioning in the wheelchair every 2-4 hours. Incontinence care (brief changes) is also required every 2-4 hours. Wound Care Registered Nurse #1 deemed the ulcers were unavoidable due to risk factors, including incontinence, agitation, and frequent movements. The nurse noted that leaving the resident in the wheelchair all night without repositioning or changing would cause the pressure ulcer to deteriorate. Wound Care Registered Nurse #1 stated that the electronic medical record system did not allow certified nursing assistants to document turning and positioning, making it impossible to verify if the plan of care was followed. Wound Care Registered Nurse #1 believed the Director of Nursing Services was aware that the electronic medical record system was not functioning correctly. During a re-interview on 03/13/2026 at 9:36 AM, Licensed Practical Nurse #1 stated they did not speak to Certified Nursing Assistant #1 about Resident #180 being left in the wheelchair all night because Certified Nursing Assistant #1 had their job, and they had their own job. Licensed Practical Nurse #1 stated they were busy as they were the only medication nurse on the 11:00 PM - 7:00 AM shift for the entire unit. They regularly see Resident #180 at night sleeping in a wheelchair. Resident #180 did better in the wheelchair because when they are placed in the bed they would get out and crawl around the room and the unit. Licensed Practical Nurse #1 stated they have their own assignment to follow and are not responsible for monitoring the certified nursing assistants to see if the certified nursing assistants are providing resident care. During an interview on 03/13/2026 at 9:43 AM, the Director of Nursing Services stated the staff should have provided incontinence and toileting care and turning and positioning as per Resident #180's plan of care. Resident #180 should not have been left in their wheelchair all night long. This situation created a likelihood for the deterioration of the existing wound and development of new wounds. The Director of Nursing Services stated the electronic medical record system does not allow the certified nursing assistants to document provision of turning and positioning and toileting every 2-4 hours. The Director of Nursing Services stated they did not know how long the electronic medical record system has not been working properly; however, the Information Technology staff is working to resolve the issue. The Director of Nursing Services stated at this time there was no evidence to show that the staff was providing turning and positioning and toileting care to the residents. During an interview on 03/13/2026 at 12:08 PM, The Administrator stated the staff must follow the resident's plan of care including brief change every 2-4 hours and turning and positioning every 2-4 hours. The Administrator stated they were not clinical and expected clinical staff to follow the resident's plan of care and document provision of care. During an interview on 03/13/2026 at 12:38 PM, the Medical Director stated that when a resident is not provided with incontinence care and is not turned and positioned every 2-4 hours, they can develop pressure ulcers or the current pressure ulcers could deteriorate and develop infection if the resident is left sitting in urine and feces. Resident #180 should have been placed in bed and not left in the wheelchair for a long time. 10 New York Codes, Rules, and Regulations 415.12(c)(1)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to develop a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet each resident's medical and nursing needs that are identified in the comprehensive assessment. This was identified for one (1) of two (2) residents reviewed for skin conditions. Specifically, Resident #12 had a physician's order for contact precautions due to extended-spectrum -lactamase infection (antibiotic resistant bacteria) in the coccyx wound and enhanced barrier precautions for the wounds on both heels. There was no comprehensive care plan developed with interventions to address the resident's enhanced barrier precaution and contact precautions status.The finding is:The facility comprehensive care plan policy last reviewed on 2/2/2026 documented a comprehensive person-centered care plan including measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The comprehensive person-centered care plan is developed within seven days of the completion of the required assessment such admission, annual or significant change in status, and no more than 21 days after admission. The assessments of residents are ongoing, and care plans are revised as information about the residents and resident conditions change. The interdisciplinary team reviews and updates the care plan.Resident #12 was admitted to the facility with diagnosis including acute embolism and thrombosis (a blood clot forms in the deep veins) of right lower extremity, non-pressure chronic ulcer of the right foot, and extended spectrum beta lactamase infection of the skin and subcutaneous tissue. The Quarterly Minimum Data Set, dated [DATE] documented a Brief Interview of Mental Status score of 11, indicating the resident had moderate cognitive impairment. The Minimum Data Set assessment documented the resident had one (1) stage 3 pressure ulcer as well as three (3) venous and arterial ulcers. The minimum data set did not indicate the resident was on any transmission-based precautions.The current physician's order dated documented contact precautions for extended-spectrum -lactamase infection of the coccyx wound and enhanced barrier precautions secondary to wounds on both heels. During an observation on 03/10/2026 at 6:56 AM, a contact precautions signage was placed outside Resident #12's room door. A green dot was noted next to Resident#12's name which indicated resident was also on enhance barrier precautions, as per the facility infection control policy.A review of Resident #12's medical record revealed there was no comprehensive care plan with interventions to address the enhanced barrier precaution and contact precautions status.During an interview on 03/15/2026 at 10:07 AM, the Wound Care Nurse stated the resident was on contact precautions and enhanced barrier precautions as per the physician's orders and the infection control care plan should have been initiated and continued until the contact precautions and enhanced barrier precautions were resolved.During an interview on 03/15/2026 at 10:42 AM, the Director of Nursing Services stated the infection control care plan should have been initiated to address Resident #12's enhanced barrier precaution and contact precaution status.10 NYCRR 415.11(c)(1)

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	335839	A. Building B. Wing	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Affinity Skilled Living and Rehabilitation Center	305 Locust Avenue Oakdale, NY 11769

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure that each resident was treated with respect and dignity and in a manner and in an environment that promotes maintenance or enhancement of their quality of life. This was identified for one (1) (Resident #104) of two (2) residents reviewed for Dignity. Specifically, during multiple observations, Resident #104 was observed in their room with a urinary catheter drainage bag that was not covered. The urinary catheter drainage bag was half-filled with urine and was visible from the hallway. The finding is:The facility's policy titled, Dignity last revised on 02/02/2026 documented that residents shall be treated with Dignity and respect at all times. Treated with Dignity means the resident will be assisted in maintaining and enhancing their self-esteem and self-worth. Demeaning practices and standards of care that compromise dignity are prohibited. Staff shall promote dignity and assist residents as needed, including keeping the urinary catheter bags covered.Resident #104 was admitted with diagnoses including neuromuscular dysfunction of the bladder (loss of bladder control caused by nerve damage), hemiplegia and hemiparesis (one sided body impairment), and urinary retention (inability to fully or partially empty the bladder). The Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented Resident #104 was rarely and never understood and had severe cognitive impairment. Resident #104 had an indwelling catheter (a flexible tube inserted into the bladder to drain urine, held in place by a water filled balloon).A Comprehensive Care Plan (CCP) titled, Altered Health Maintenance: Foley Catheter dated 09/23/2024 and revised on 02/09/2026 documented interventions including, ensuring that the Foley (urinary) drainage bag is not touching the floor, observe for decrease urinary output or leakage, and empty the Foley drainage bag every shift.A Physician Order dated 11/23/2025 documented Foley catheter,16 French (specific outer diameter of the tube), 10 milliliters balloon for diagnosis of neurogenic bladder (loss of bladder control caused by nerve damage).A Physician Order dated 12/31/2025 documented Foley catheter care every shift.During an observation on 03/09/2026 at 11:05 AM, Resident #104 was in bed with a Foley catheter drainage bag that was not covered and was visible from the hallway. The Foley catheter drainage bag was half filled with yellow colored urine.During an observation on 03/09/2026 at 12:41 PM, Resident #104 was eating their lunch in bed. Resident #104 had a Foley catheter drainage bag that was not covered and was visible from the hallway. The Foley catheter drainage bag was half filled with yellow colored urine.During an observation on 03/13/2026 at 9:00 AM, Resident #104 was in bed with a Foley catheter drainage bag lying on Resident #104's landing mat (soft, thick, foldable mat designed to cushion a landing, fall or mishap) and was visible from the hallway. The Foley catheter drainage bag was half filled with yellow colored urine. The Foley catheter drainage bag was not covered with a privacy cover.During an interview on 03/09/2026 at 12:45 PM, Certified Nursing Assistant #4 stated that they did not notice that Resident #104's Foley catheter drainage bag was not covered with a privacy bag. Certified Nursing Assistant #4 stated they were busy providing care to other residents and forgot to put the privacy cover for Resident #104's Foley catheter drainage bag.During an interview on 03/11/2026 at 8:01 AM, Licensed Practical Nurse #5, Medication Nurse, stated that the Certified Nursing Assistants are responsible for placing the privacy covers for the Foley catheter. Licensed Practical Nurse #5 stated they were not sure if there was a privacy cover for Resident #104's Foley catheter drainage bag when they went into administer Resident #104's medications on 03/09/2026.During an interview on 03/13/2026 at 9:13 AM, Certified Nursing Assistant #5 stated that they did not notice that Resident #104's Foley catheter drainage bag did not have a privacy cover when they (Certified Nursing Assistant #5) had provided care for Resident #104 early in the morning. Certified Nursing Assistant #5 stated they were busy doing care with other residents and did not check if Resident #104's Foley catheter drainage bag was covered with a privacy cover.During an (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 03/16/2026 at 10:17 AM, the Director of Nursing Services stated that Resident #104's Foley catheter drainage bag should have been covered with a privacy bag. The Director of Nursing Services stated that they expect their staff to ensure that all residents are cared for in a dignified manner.10 NYCRR 415.5(a)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to ensure that each resident had secure and confidential medical records. This was identified for one (1) (Resident #27) of five (5) residents reviewed for the Medication Administration Task. Specifically, Licensed Practical Nurse #1 left Resident #27's electronic record open in the hallway with the personal and medical information visible to other staff, residents, and visitors.The finding is:Resident #27 was admitted with diagnoses that included fracture of the finger in the right hand, cerebral infarction (lack of blood supply to the brain tissue causing tissue death), chronic obstructive pulmonary disease (long-term lung disease that makes breathing difficult). The admission Minimum Data Set assessment dated [DATE], documented a Brief Interview for Mental Status score was not completed as Resident #27 was rarely or never understood.During a medication pass observation on 03/10/2026 at 6:33 AM, Licensed Practical Nurse #1 went into Resident 27's room to administer medications to the resident and left the computer screen open and visible to other staff, residents, and visitors in the hallway. During an interview on 03/10/2026 at 6:33 AM, Licensed Practical Nurse #1 stated the resident's personal and medical information should be protected and the computer screen should have been closed.During an interview on 03/15/2026 at 7:20 AM, the Director of Nursing Services stated to protect the resident personal and medical information, the computer screen needs to be minimized or closed when not in use.10 NYCRR 415.3(e)(1)

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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. Based on observations, record review and interviews, the facility failed to ensure that each resident was free from physical restraints that was used for the purpose of discipline or convivence; and that the restraint was used to treat the residents' medical conditions with ongoing re-evaluation of the need for the physical restraint. This was identified for one (1) (Resident #180) of one (1) resident reviewed for restraints. Specifically, Resident #180 had diagnoses including down syndrome with severely impaired cognition and a facility acquired stage 3 pressure ulcer to their right buttock. Resident #180 was physically restrained with an upper body Posey belt (a harness-like belt that wraps the resident's trunk to keep the resident in an upright position) with no documented evidence of a physician's order, the medical necessity, care instructions for nursing staff, or ongoing monitoring and re-evaluation of the need for the physical restraint. Additionally, there was no documented evidence that a consent to use the restraint was obtained and the resident representatives were informed of the risks and benefits of the restraint being used for Resident #180.Cross Reference: F684 Quality of CareThe finding is:The facility policy titled Restraints last reviewed 02/02/2026 documented the primary focus is to ensure the safety and well-being of residents while minimizing the use of restraints to the greatest extent possible. Informed consent must be obtained from the resident or their legally authorized representative before implementing any restraint. The healthcare team must provide a clear explanation of the reasons for restraint use, potential risks and benefits, and alternatives. Residents under restraint must be closely monitored, and the effectiveness of restraint interventions must be regularly evaluated. Thorough and accurate documentation is essential for all aspects of restraint use, including initial assessment, informed consent, ongoing monitoring and evaluations. Resident #180 was admitted with diagnoses that included down syndrome (genetic condition caused by an extra copy of chromosome 21 leading to intellectual disability, developmental delays, and distinct physical features and low muscle tone), pressure ulcer right buttock stage III, and bipolar disorder (chronic mental health condition characterized by intense alternating mood swings). The Quarterly Minimum Data Set (a resident assessment tool) dated 12/13/2025 documented a Brief Interview for Mental Status score was not completed as the resident was never understood and had severely impaired long and short term memory. The Minimum Data Set documented Resident #180 used a wheelchair and was dependent on two (2) staff members for all aspects of care. The Quarterly Minimum Data Set assessment documented Resident #180 had no restraints in and out of bed.A Comprehensive Care Plan dated 09/10/2025 and last reviewed 12/15/2025, documented Resident #180 requires restraint alternative use secondary to inability to sit up on their own and maintain proper body alignment. Interventions included quarterly review and evaluation of use and for possible reduction. Inform family representative of benefits and risks associated with restraint use.A Restraint Alternative vs Restraint Determination assessment form dated 09/08/2025 documented Resident #180 was evaluated for a restraint alternative or restraint for the following reasons: tend to lean forward, and poor trunk control. The medical symptoms were leans forward and impulsive behavior. The device (name of device not indicated) is appropriate to maintain resident safety due to impulsive movements. The assessment form did not indicate the team's decision whether the device was a restraint alternative or a restraint. The form did not indicate the resident representative was notified. A physician's order dated 09/09/2025 documented out of bed to personal tilt-in-space wheelchair.A review of the physician's orders revealed no documented evidence of orders for the use of the Posey belt restraint, monitoring or skin check instructions related to the use of the restrictive device.A review of the medical record from 12/01/2025-03/09/2026 revealed multiple nursing progress notes indicating Resident #180 was found crawling out of bed on the floor and into the hallway. Resident #180 was redirected back to their room and was placed in their wheelchair.During an observation on 03/10/2026 at 06:51 AM, Resident #180 was observed in a dark (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room sitting upright on a roho cushion (a specialized cushion for pressure relief) in a tilt in space wheelchair. The resident was strapped to their wheelchair with a Posey restraint. Resident #180 was making loud incoherent random sounds. During an observation on 03/12/2026 at 04:20 AM, Resident #180 was in their room in the dark, sleeping in their wheelchair while sitting upright on a roho cushion. The resident was restrained with a Posey belt that was attached to the wheelchair with their hands secured under the Posey belt.During an observation on 03/12/2026 at 05:06 AM, Resident #180 was in their room in the dark, sleeping in their wheelchair while sitting upright on a roho cushion. The resident was restrained with a Posey belt that was attached to the wheelchair with their hands secured under the Posey belt.During an observation on 03/12/2026 at 06:07 AM, Resident #180 was sitting on a roho cushion in their wheelchair. The resident was awake. Resident #180 was able to remove their hands from under the Posey belt; however, they could not release the Posey belt on request. During an interview on 03/12/2026 at 06 :09 AM, Certified Nursing Assistant #1 (assigned to Resident #180) stated Resident #180 was usually in bed when they come in for their 11:00 PM to 07:00 AM shift; however, last night they came in at 03:00 PM and were assigned to Resident #180 for both shifts. Certified Nursing Assistant #1 stated they put Resident #180 into bed at 11:00 PM on 03/11/2026 and took the resident out of bed to the wheelchair about a half an hour ago (05:39 AM). Certified Nursing Assistant #1 they were not aware that Resident #180 was in the wheelchair at 04:20 AM and 05:06 AM and reiterated that they transferred Resident #180 into the wheelchair half an hour ago, without assistance from anyone. During an interview on 03/12/2026 at 09:52 AM, Licensed Practical Nurse #1 stated Resident #180 was in their wheelchair sleeping when they started their shift on 03/11/2026 at 11:00 PM. During their rounds they went into the resident's room on 03/12/2026 at 02:55 AM and Resident #180 was asleep in their wheelchair. Licensed Practical Nurse #1 stated they returned to the resident's room at 05:30 AM to administer the medications and observed Resident #180 sleeping in the wheelchair. Licensed Practical Nurse #1 stated the wheelchair Posey belt was restraining and did not know if skin checks were needed when utilizing a restraining device. During a re-interview on 03/13/2026 at 9:36 AM, Licensed Practical Nurse #1 stated they did not speak to Certified Nursing Assistant #1 about Resident #180 being left in the chair all night because Certified Nursing Assistant #1 had their job, and they had their own job. Licensed Practical Nurse #1 stated they were busy as they were the only medication nurse on the 11:00 PM-7:00 AM shift for the entire unit. They regularly see Resident #180 at night sleeping in a wheelchair. Resident #180 did better in the wheelchair because when they are placed in the bed they would get out and crawl around the room and the unit. Licensed Practical Nurse #1 stated they have their own assignment to follow and are not responsible for monitoring the certified nursing assistants to see if the certified nursing assistants are providing resident care.During an interview on 03/13/2026 at 9:43 AM, the Director of Nursing Services stated harness-like belt is a Posey assistive device and was not considered a restraint even though Resident #180 was unable to open the Posey assistive device on request. The Director of Nursing Services stated that the Posey assistive device did not require a physician's order. During an interview on 03/13/2026 on12:08 PM, the Administrator stated they were not clinical and expected clinical staff to follow the resident's plan of care and document provision of care. During an interview on 03/13/2026 at 12:38 PM, the Medical Director stated the nurse should have asked for an order for the Posey restraint for Resident #180.10 NYCRR 415.4(a)(2-7)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility did not ensure that each resident's environment remained free of accident hazards. This was identified for one (1) (Resident #28) of four (4) residents reviewed for Accidents. Specifically, an unsecured oxygen E-Cylinder tank (a portable, high-capacity metal cylinder used to store compressed medical grade oxygen) was observed on Resident 21's bed side. The E-Cylinder tank was not secured in a holder or a metal rack.The finding is: The facility's policy, titled Oxygen Cylinder Storage last revised on 02/02/2026, documented that the facility will store, handle, and maintain oxygen cylinders in a safe manner. Oxygen cylinders should be stored to prevent tipping, damage, contamination, or fire hazards and should be readily accessible for resident care needs while ensuring staff and resident safety. Oxygen cylinders must be secured using racks, chains, straps, or approved carts. Cylinders must never be stored loosely on the floor. Cylinders must be protected from falling, tipping, or physical damage. Cylinders stored in Nursing units must be secured in approved holders or carts. Resident #28 was admitted with diagnoses including shortness of breath, aphasia (language disorder caused by brain damage resulting inability to speak, understand, read and write) and traumatic brain injury (caused by external force). The Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented that Resident #28 was rarely and never understood. Resident #28 had severe cognitive impairment. A review of Resident #28's electronic medical record revealed that Resident #28 did not have a physician's order for the use of oxygen. A Comprehensive Care Plan (CCP) titled, Altered Health Maintenance: Resident noted with acute or potential condition, upper respiratory infection, sore throat, dry and moist protective cough dated 12/04/2025 last revised on 12/30/2025 documented interventions including antibiotic therapy, oxygen as needed, and bedrest as needed. During an observation on 03/09/2026 at 11:13 AM, Resident #28 was in bed sleeping. A free-standing E-cylinder oxygen tank was on the left side of Resident #28's bed. The E-tank oxygen gauge (a device that measures the pressure of oxygen in a tank to determine the remaining volume) arrow was pointed in the middle dial, indicating the amount of oxygen present in the tank. The E-Cylinder tank was not secured in a holder, rolling safety stand, or a metal rack. During an interview on 03/09/2026 at 11:24 AM, Licensed Practical Nurse #7, Medication Nurse, stated that Resident #28 uses oxygen therapy as needed. Licensed Practical Nurse #7 stated they did not see the free-standing E-Cylinder tank when they gave medications to Resident #28 in the morning. Licensed Practical Nurse #7 stated that the E-Cylinder tank should be secured with a rolling safety stand or a metal rack. During an interview on 03/09/2026 at 2:10PM, Certified Nursing Assistant #6 stated that they did not see the free-standing E-Cylinder tank in Resident #28's room when they provided morning care to Resident #28. Certified Nursing Assistant #6 stated that the E-Cylinder tank should have been secured on a rolling safety stand. During an interview on 03/09/2026 at 2:38PM, Licensed Practical Nurse #8, Charge Nurse, stated that Resident #28 should not have any free-standing E-Cylinder tank in their room. Licensed Practical Nurse #8 stated that there are plenty of rolling safety stand in the unit to secure the E-Cylinder tank. Licensed Practical Nurse #8 stated they did not know that Resident #28 was on oxygen therapy. During an interview on 03/16/2026 at 10:12 AM, the Director of Nursing Services stated that staff should use a rolling safety stand when securing an E-Cylinder tank. The Director of Nursing Services stated that a free-standing E-Cylinder tank is unsafe and can cause injury. The Director of Nursing Services stated that all staff members are responsible for checking each resident room for any hazards including unsecured oxygen tanks. 10 NYCRR 415.12(h)(1)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to ensure that residents who have an indwelling catheter received the appropriate care and services to prevent urinary tract infections to the extent possible. This was identified for one (1) (Resident # 40) of four (4) residents reviewed for Urinary Catheter. Specifically, Resident #40 was admitted to the facility with a chronic long-term Foley catheter. On 03/09/2026, Resident #40 was observed with the Foley catheter drainage bag stored above their waistline causing potential for urinary retention and the urine to flow back into the bladder.The finding is: The facility policy and procedure for Foley Catheter dated 2/2/2026 documented that the purpose of this procedure is to prevent infection of the resident's urinary tract. The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder. Resident #40 was admitted with the diagnosis of benign prostatic hyperplasia without lower urinary tract symptoms The Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 15, which indicated the resident was cognitively intact. The resident required substantial/maximal assistance for toilet use. The resident was non-ambulatory and had an indwelling catheter. The urinary incontinence and indwelling catheter comprehensive care plan dated 03/06/2026 documented indwelling catheter in place for urinary retention, with increased risk for urinary tract infection secondary to Foley catheter and history of urinary tract infection, increased risk for dehydration with urinary tract infection. Interventions included to ensure the Foley drainage bag is not touching floor, conduct ongoing assessment for urinary tract infection, change Foley catheter per physician orders, empty drainage bag every shift and assure that the drainage bag is clean, covered, and positioned below the indwelling catheter. The physician's orders dated 03/09/2026 documented Foley catheter 18 French (size) With 30 cubic centimeter balloon (used to hold catheter In place) due to urinary retention related to diagnoses of obstructive uropathy and neurogenic bladder; change Foley catheter every four (4) weeks; flush Foley catheter every shift with 30-50 cubic centimeter normal saline as needed and provide Foley catheter care every shift. During an observation on 03/09/2026 at 10:15 AM, Resident # 40 was in their room seated in their wheelchair. The resident's Foley catheter drainage bag that was connected to the resident's Foley catheter was stored above the resident's waist level, on the resident's wheelchair arm pad. During an observation with the Licensed Practical Nurse #3 on 03/09/2026 at 11:15 AM, Resident #40 was observed with their Foley catheter drainage bag stored above the resident's waist level. Licensed Practical Nurse #3 stated they did not realize that the Foley drainage bag was not stored properly and that the bag should be below the resident's waist level. During an interview on 03/09/2026 at 11:17 AM, Registered Nurse #1 stated that the foley drainage bag should not be placed above the resident's waistline. Registered Nurse #1 stated if the urinary drainage bag is placed above the Foley catheter and the bladder, the urine would not drain properly and could cause an infection and urinary retention. During an interview on 03/12/2026 at 12:10 PM, the Director of Nursing Services stated the urinary drainage bag should be placed below the urinary catheter site so the urine could drain effectively. If the drainage bag is above the waistline, this can cause urinary retention and infections. During an interview on 03/17/26 at 11:45 AM, the Medical Director stated the urinary drainage bag should not be placed above the resident's bladder level for effective urinary drainage. If the bag is above the bladder, the urine would not be able to drain. This can cause urinary retention and infections. 10 NYCRR 415.12(d)(1)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews during a recertification survey, the facility failed to ensure the provision of care and services necessary to maintain acceptable parameters of hydration status. This was identified for one (1) (Resident #277) of eight (8) residents reviewed for nutrition and for one (1) (Resident #14) of one (1) resident reviewed for Dialysis. Specifically. The facility did not monitor and document the fluid intake for Resident #277 and Resident #14 who had a physicianˆordered 1200 milliliter (mL) fluid restriction. As a result, the facility staff were unable to determine whether the residents' prescribed fluid restriction orders were followed, placing the residents at risk for fluid imbalance.The findings are: A facility policy and procedure titled Fluid Restriction, dated 02/02/2026, documented fluid restrictions will be followed as per Physician's orders and follows the procedures: the amount of fluid allowed in a 24-hour period will be specified in a physician's order and sent to dietary [department] via electronic medical record system. The dietary department and nursing department will determine how much fluid will be provided at meals and medication passes. No water will be provided at the bedside unless calculated into the daily total fluid restriction. -Resident #277 was admitted on [DATE] with diagnoses including dehydration, acute kidney injury on chronic kidney disease, and acute heart failure. The admission Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) of 15, indicating the resident had intact cognition. Resident #277 did not exhibit any behaviors or refusal of care/treatment, was independent for feeding, and had no signs or symptoms of dehydration. A Physician's order dated 03/05/2026, documented Diet: No Added Salt with a 1200 milliliter fluid restriction with special instructions to use 60 milliliters of fluid per medication pass. The order did not specify the reason for the fluid restriction. A dietary progress note dated 03/06/2026 documented Resident #277 had a physician's diet order of no added salt and a 1200 milliliter fluid restriction. Resident #277's appetite was good, with approximately 75 percent of meals with fluids intake. A nursing progress note dated 03/06/2026 documented Resident #277 had good appetite, and fluids were encouraged and tolerated. The note did not specify the amount of fluid consumed by the resident in numerical form to determine a total of 1200 cubic centimeter of fluid intake. A medical progress note dated 03/07/2026 documented Resident #277 has diagnoses of heart failure and acute and chronic renal failure. The plan included monitoring renal function, continue medication of Lasix (diuretic) 20 milligrams daily, monitor fluid status and weights, and a 1200 milliliter fluid restriction. A comprehensive care plan titled Nutritional Status, effective 03/06/2026, documented Resident #277 required a therapeutic diet, with goals to consume food and fluids as tolerated. Interventions included providing adequate proteins, calories, and fluids to meet estimated needs, monitoring laboratory values, documenting and reporting dietary noncompliance, encouraging and monitoring meal intake; monitoring weight; and providing the diet as ordered. A comprehensive care plan titled Risk for dehydration secondary to diuretic therapy and a 1200 (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	milliliter fluid restriction per 24 hours; a goal that resident will consume fluids as tolerated 840 milliliters from dietary, 180 milliliters from medications, and 180 milliliters from recreation. Interventions included monitoring output, monitoring labs, and encouraging intake as appropriate. A review of the electronic medical record Medication Administration Record from 03/05/2026 to 03/16/2026 and meal intake record 03/06/2026 to 03/16/2026 indicated no evidence that the fluid intake was recorded to quantify the amount of fluid consumed by the resident in numerical form to ascertain 1200 cubic centimeter of fluid intake by the resident. During an interview on March 12, 2026, at 4:23 PM, the Registered Dietitian stated that fluid amounts provided on the meal trays are listed in the dietary computer system and that the nursing staff was verbally instructed to use 60 milliliters of fluid for medication administration for each shift. The Registered Dietitian confirmed that the resident's total daily fluid intake is not documented. During an interview on 03/17/2026 at 11:54 AM, the Director of Recreation stated that recreation staff review diet restrictions before activities and communicate with nursing regarding fluid allowances. They further stated that there is no place for staff to document the amount of fluid provided or consumed by the resident. During an interview on 03/17/2026 at 12:06 PM, Certified Nursing Assistant #10 stated they document food and fluid intake on the resident's profile in the electronic medical record. They do not give Resident #277 extra fluids during the day. Certified Nursing Assistant #10 reviewed the meal intake record and confirmed that there was no fluid intake documented, only a percentage for the meal. During an interview on 03/17/2026 at 12:10 PM, Licensed Practical Nurse #15 stated they rely on the physician orders to identify fluid restrictions, but do not document fluid consumption in the medication administration record. Licensed Practical Nurse #15 stated they write a daily note indicating the resident is on a restriction; however, they do not document actual amount of fluid consumed by the resident. -Resident #14 was admitted with diagnoses that included end stage renal disease, arteriovenous fistula, and diabetes mellitus. The annual Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score was 8, which indicated moderately impaired cognition. The resident received dialysis. A Comprehensive Care Plan for dehydration dated 2/25/2021 and last updated 01/23/2026 documented the resident was at risk for dehydration due to dementia, dependent on staff for fluid, potential for electrolyte imbalance, and fluid restriction 1200 milliliters/24 hours. Interventions included dietary consultation as needed, encourage fluid and food intake as appropriate, monitor for change in output and to monitor for signs and symptoms of dehydration such as poor skin turgor, dry mouth, thirst, and change in mental status. A Comprehensive Care Plan for Stage 4 renal failure dated 2/25/21 and updated 01/23/2026 documented the resident was at risk for excess fluid retention and to monitor the resident's weight as per the physician's order. A current physician's order documented to maintain fluid restriction of 1200 cubic centimeters a day, every shift in total. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Certified Nursing Assistant fluid intake record for Resident #14 dated from 02/17/2026 to 03/17/2026 revealed inconsistent entries for the fluid intake consumed by the resident. The examples included but were not limited to 02/17/2026, 02/18/2026, 02/19/2026, 02/21/2026, 02/22/2026, 02/23/2026, 02/25/2026, 02/27/2026, 02/28/2026, 03/02/2026, 03/03/2026, 03/04/2026, 03/07/2026, 03/08/2026, 03/09/2026, 03/11/2026, 03/12/2026, 03/13/2026, 03/15/2026, 03/16/2026 and 03/17/2026 there were missing entries for the resident's fluid intake on the meal consumption records for various meals. A review of the medication administration record for the month of march indicated no record of the resident fluid intake for all medication administration. A review of the nursing progress notes for the month of March 2026 there were no entries related to the amount of fluid consumed. During an interview on 03/17/2026 at 10:21 AM, Licensed Practical Nurse #13, the unit manager, stated that the resident was on 1200 cubic centimeter fluid restriction and that the certified nursing assistants were responsibility for recording the resident's fluid intake for each meal on the electronic Meal Consumption Record. Licensed Practical Nurse #13 stated that nursing is allotted 360 cubic centimeters of the 1200 cubic centimeters fluid daily, for medication pass. Licensed Practical Nurse #13 stated that the fluids given by the nurses during medication pass were not documented. Licensed Practical Nurse #13 stated that they were responsible for monitoring the certified nursing assistants to ensure the resident's fluid intake was being documented on the Meal Consumption Record. During an interview on 3/17/26 at 10:24 AM, Licensed Practical Nurse #14 stated that the residents receive 240 cubic centimeters of fluid with their morning and the afternoon medication administration pass. Licensed Practical Nurse #14 stated that they do not document the amount of fluid they administer with medication as the Dietitian had already calculated the amount of fluid the nurses were to administer with their medications administration pass. During an interview on 03/17/2026 at 10:42 AM, the Dietitian stated the resident was on a 1200 cubic centimeters fluid restriction. The Dietitian stated dietary was responsible for 860 centimeters of fluid and nursing was responsible for 340 centimeters of fluid for all medication administration pass. The Dietitian stated the 860 cubic centimeters fluid amount includes all liquids served on the resident's meal tray and nursing staff are responsible for monitoring and documenting the fluid intake. During an interview with the Medical Director on 3/17/26 at 1:01 PM, the Medical Director stated that when a resident is on fluid restriction their expectation is that the intake should be monitored and documented to ensure that the resident is receiving the prescribed amount of fluid to prevent fluid over loaded, that the staff knows what the resident intake is, and that the order is followed. The Medical Director stated residents with a diagnosis of congestive heart failure and end stage renal failure are at risk for fluid overload when their fluid intake is not carefully monitored. The Medical Director further stated that the residents plan of care should be followed as written. During an interview on 03/17/2026 at 1:14 PM, the Director of Nursing Services stated that the certified nursing assistants should document the amount of fluid the resident received with each meal for all residents on fluid restriction. The Director of Nursing stated for residents on fluid restrictions, the fluids administered by the nurses during medication administration pass, should be documented on the Medication Administration Record; however, the facility electronic medical record system was not set up for the nurses to record the fluid amount. The Director of Nursing Services stated that going (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	forward dietary will set up the system where the fluids given by the nurse are documented on the Medication Administration Record. The Director of Nursing Services stated that the nurse manager should be monitoring the Meal Consumption Record and the Medication Administration Record for completion and accuracy. The Director of Nursing stated that the unit nurse manager should ensure that the nursing staff document the actual amount of fluid consumed by the resident, during meals and medication administration, in numerical form instead of the percentage to calculate a total of 1200 fluid restriction is followed. The Director of Nursing Services further stated not monitoring the fluid intake could lead to potential for fluid overload for residents on fluid restriction. 10 NYCRR 415.12 (i) (1)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, record review and interviews, the facility did not ensure medications were properly stored in medication carts. This was identified for one (1) (Unit 3 southwest medication cart) of eight (8) medication carts reviewed during the medication storage task and Medication Administration task. Specifically, an unlocked and unsupervised medication cart was observed on unit 3 southwest in the hallway. There was no nursing staff present in the vicinity of the medication cart.The finding is:The facility policy titled Storage of Medications last reviewed 02/02/2026, documented the medication nurse on duty is responsible for the security of the carts contents. The cart must be locked and secure at all times when not in use.The facility policy titled Medication Administration, last reviewed 02/02/2026 documented to keep all mediations under lock and key.During a medication pass observation on 03/10/2026 at 6:33 AM, Licensed Practical Nurse #1 went into Resident 27's room to administer their medications. Licensed Practical Nurse #1 left the unlocked medication cart unsecured and out of their view, in the hallway.During an interview on 03/10/2026 at 6:33 AM, Licensed Practical Nurse #1 stated they forgot to lock the cart and that the medication cart should be locked when they go into a resident's room and the cart is out of their view.During an interview on 03/15/2026 at 7:20 AM, the Director of Nursing Services stated they expect the nursing staff to lock the medication cart after removing medications from the cart, it should always be locked when not in use.483.45(g)(h)(1)(2)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews, the facility did not ensure that food was prepared, distributed, and served in accordance with professional standards for food service safety. This was identified for one (1) (Resident #74) of four (4) residents reviewed for Tube Feeding. Specifically, Resident #74's tube feeding formula and the water bags were unlabeled and did not indicate the resident's name, the date, or the time the tube feeding was initiated.The finding is:The facility policy titled Gastronomy Feedings last reviewed 02/02/2026, had no documentation for labeling the feeding with the resident's name date and start time. The policy documented disposable equipment is to be changed every 24 hours or as necessary. The Feeding is to be disposed within 24 hours of feeding administration.Resident #74 was admitted with diagnoses that included traumatic subdural hemorrhage (blood collects between the brain and its outer most covering after a head injury), nondisplaced fracture of first cervical vertebra (spine), and Anoxic brain damage (when oxygen is cutoff to the brain leading to brain cell death). The Quarterly Minimum Data Set assessment dated [DATE], documented Resident #74 had a Brief Interview for Mental Status score of 99, indicating the resident could not complete the interview and had severe cognitive impairment. The Quarterly Minimum Data Set assessment documented Resident #74 had a gastronomy tube for nutrition.The Comprehensive Care Plan titled Tube Feed dated 12/13/2024, documented provide tube feed regimen as ordered by the Physician.The Comprehensive Care Plan titled Risk for Dehydration dated 12/13/2024, documented interventions that included providing hydration fluids via gastronomy tube to meet hydration needs.A physician's order dated 10/06/2025, documented Jevity 1.5 formula, via feeding pump, at a rate of 75 cubic centimeters per hour, to run thirteen (13) hours or until volume completes, total volume 1000 cubic centimeters. 760 cubic centimeters of water in formula, 50 cubic centimeters of water before starting feeding and at the end of feeding, and an auto flush of 95 cubic centimeters every hour until total feeding completes. Total auto flush volume is 1235 cubic centimeters, total water 2095 cubic centimeters. Total volume 2335 cubic centimeters. Start feeding at 4:00 PM daily and run till completed.A review of the Medication Administration Record for March 2026 was documented by each shift on 03/09/2026. There was no documented evidence that the gastrostomy feeding was started at 4:00 PM.On 03/09/2026 at 11:04 AM, Resident #74 was observed in bed. The resident's representative was at the bedside. A tube feeding of Jevity 1.5 was observed hanging and running, it was un-labeled, no name, date or time hung was documented on the bottle of Jevity 1.5.During an interview on 03/09/2026 at11:30 AM, the assigned 7:00 AM-3:00 PM shift Licensed Practical Nurse #10 observed the tube feeding currently running for Resident #74 and stated the gastrostomy feeding formula bottle was not labeled with resident's name with date and time the formula was hung. Licensed Practical Nurse #10 stated Resident #74's feeding starts at 4:00 PM every day and should run approximately 13 hours or until it is finished. Licensed Practical Nurse #10 stated the nurse who hung the feeding should have labeled the bottle, with the name of the resident, the time and date it was hung and the volume to infuse hourly and the total volume to infuse. They were unsure as to why the feeding currently hanging was not labeled, they stated they should have noticed this when they were in the room to give the resident medications, and water flushes as ordered. During an interview on 03/13/2026 at 2:30 PM, Licensed Practical Nurse #11, the medication nurse who initiated the feeding on 3/8/2026 at 4:00 PM, stated the tube feeding bottle should be labeled with the rate, the resident's name, time the bottle was hung, and the date. They were unsure why they did not label the feeding on 03/08/2026 it was an oversite.During an interview on 03/15/2026 at 7:18 AM, the Director of Nursing Services stated the tube feeding bottle should be labeled with the resident's name, time hung, and date. They expect the nurses who are on the following shifts to check to see if the tube feeding formula bottle is labeled and running as ordered.10 NYCRR 415.14(h)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. This was identified for one (1) (Resident #12) of two (2) residents reviewed for skin conditions. Specifically, Resident #12 had a physician's order for Enhanced Barrier Precautions and Contact Precautions. Certified Nurse Assistant #3 was wearing two pairs of gloves, did not have a protective gown on, and their surgical mask was observed under their mouth.The finding is:The facility's Infection Control policy last reviewed on 8/2025 documented that any resident suspected or diagnosed as having communicable diseases shall be placed in the appropriate type of isolation precautions. For contact precautions, gowns are indicated if soiling is likely and if contact with the resident or handling of items in the room are expected. Wear Gloves when entering the room. Change after contact with infective material. Gloves are to be removed and discarded before leaving the room. All healthcare workers, visitors and residents will follow established precautions as well as any special instructions that become necessary.The Enhanced Barrier Precaution Policy dated 8/2025 documented to implement enhanced barrier precaution during high contact resident care activities for those residents who are within multidrug resistant organisms unless otherwise ordered by the primary medical doctor. An example of high contact resident care activities including dressing, bathing, showering, changing linens, changing briefs or assisting with toileting. The facility will implement enhanced barrier precautions to include any resident including chronic wounds and venous status ulcers. Gowns and gloves are needed when providing high contact resident care activities.Resident #12 was admitted to the facility with diagnoses including acute embolism and thrombosis (a blood clot forms in the deep veins) of unspecified deep veins of right lower extremity, non-pressure chronic ulcer of the right foot, and extended spectrum beta lactamase infection of the skin and subcutaneous tissue. The Quarterly Minimum Data Set, dated [DATE] documented the resident had a Brief Interview of Mental Status of 11, indicating the resident had moderate cognitive impairment. The Minimum Data Set assessment documented the resident had one (1) stage 3 pressure ulcer as well as three (3) venous and arterial ulcers. The resident was always incontinent with bowel and bladder and required assistant with toileting.The current physician's order dated documented contact precautions for extended-spectrum -lactamase infection of the coccyx wound and enhanced barrier precautions secondary to wounds on both heels. During an observation on 03/10/2026 at 6:56 AM, a contact precautions signage was placed outside Resident #12's room door. A green dot was noted next to Resident#12's name which indicated resident was also on enhance barrier precautions, as per the facility infection control policy. Certified Nurse Assistant #3 was observed providing incontinence care for Resident #12. Certified Nurse Assistant #3 was wearing two pairs of gloves, did not have a protective gown on, and their surgical mask was observed under their mouth.During an interview on 03/10/2026 at 7:07 AM, Certified Nurse assistant #3 stated they believed Resident #12's roommate was on contact precautions. Certified Nurse Assistant #3 stated they never followed contact precautions for Resident #12 because they knew Resident #12 was not on contact precautions. Certified Nurse Assistant #3 stated they did not need to ask the nurse who was on contact precautions in the room. Certified Nurse Assistant #3 further stated that if the signage was posted on the right side of the wall, then that would indicate Resident #12 was on contact precautions. Certified Nurse Assistant #3 stated that they utilized contact precaution for the resident on the left side of the room because the contact precaution sign was posted on the left side of the door. Certified Nurse Assistant#3 stated they did not know what the green dot indicator on the contact precaution signage meant and that the contact precautions were not listed on the Certified Nurse Assistant assignments sheets. Certified Nurse Assistant #3 stated they used double gloves to protect themselves and the surgical face masks felt (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	better below their mouth.A review of Resident #12's roommate indicated that the resident did not have any transmission-based precautions ordered by a Physician.The daily certified nurse assistant assignment sheets for the unit did not indicate any transmission-based precautions for Resident #12.The nurse assistant instructions for Resident #12 documented the resident was on contact precautions and enhanced barrier precautions.During an interview on 03/12/2026 at 06:30 AM, Licensed Practical Nurse #1 stated they were aware that Resident#12 was on contact precautions; however, the signage was posted on the wrong side of the door. Licensed Practical Nurse #1 stated they were aware the signage placement was incorrect and did not get a chance to place the signage on the correct side. Licensed Practical Nurse #1 stated Resident #12 required contact precautions and enhanced barrier precautions due to an infection in their wounds.During an interview on 03/12/2026 at 06:49 AM, Licensed practical Nurse #9 stated they knew which residents were on infection control precautions because there were physician orders for the precautions. Licensed Practical Nurse #9 stated that by looking at the precaution signage posted by the door, staff would not know which resident in the room was on contact precautions. Licensed Practical Nurse #9 stated that facility does not place the precaution signage to correspond with the specific resident in the room. Licensed Practical Nurse #9 stated that nurse assistants are informed which residents are on contact precautions through verbal report at the beginning of the shift from licensed practical nurses. Licensed Practical Nurse #9 stated at the start of each shift there is a brief meeting to inform staff of residents on precautions. Licensed Practical Nurse #9 further stated a green dot next to the resident's name indicates the resident is on enhance barrier precautions.During an interview on 03/13/2026 at 09:38 AM, Licensed Practical Nurse #4 (Infection Prevention Nurse) stated irrespective of the side where the signage is posted on the door, the staff should ask the nurse which resident is on transmission-based precautions. Licensed Practical Nurse #4 stated Certified Nursing Assistant #3 should have put on a gown and the mask while providing care to Resident #12. The mask should not be worn below the mouth.During an interview on 03/15/2026 at 07:13 AM, the Director of Nursing stated it was not acceptable that the staff was unable to identify the precaution residents in the rooms. The Director of Nursing stated it is important to utilize the appropriate Personal Protective Equipment to prevent the spread of infectious organisms.10 NYCRR 415.19(a) (1-3)