

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335845	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Northeast Ctr for Rehabilitation and Brain Injury		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Grant Avenue Lake Katrine, NY 12449	
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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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 observations, interviews and record review during survey, the facility failed to ensure that the environment remained free of accident hazards and that residents received adequate supervision to prevent accidents for three of eight residents (Resident #8, Resident #33, and Resident #35) reviewed for accidents. Specifically, 1) Resident #8 sustained a fall in the shower on 10/31/2025 when Certified Nurse Aide #44 failed to maintain one-to-one supervision. 2) Resident #33 sustained a fall from bed on 06/06/2025 resulting in abrasions to their back and right elbow after Certified Nurse Aide #39 failed to lower the bed to its lowest position and place floor mats at bedside upon completion of care per the resident's care plan. Additionally, neurological checks were not completed as ordered status post fall. 3) On 12/12/2024 Certified Nurse Aide #38 transferred Resident #35 from the bed to a shower trolley using a mechanical lift and showered the resident without the assistance of another staff member. Resident #35 fell from the shower trolley and sustained bruising on their right-hand knuckles and left wrist and required 19 sutures to their right eyebrow. This resulted in actual harm that was not Immediate Jeopardy for Residents #33 and #35. The findings include: 1) Resident #8 had diagnoses that included dementia, falls, and impaired gait and mobility. The facility Fall Prevention policy last reviewed 1/2026 documented that it is the policy to provide a safe resident environment with implementation of a comprehensive fall prevention program designed to minimize the risk of resident falls while maintaining each resident's highest practicable level of independence. The physician order dated 03/17/2025 documented one to one supervision every day and every shift. The At Risk for Falls care plan initiated 08/06/2024, documented risks including confusion, history of falls, unsteady gait, and pain. Falls were documented 13 times from 08/24/2023 to 10/31/2025. Interventions included risk assessments, rehabilitation screens, encouraging proper footwear, observing if any decline in strength, mobility or balance. The Accident and Incident Report dated 10/31/2025 documented that Resident #8 was in the shower room sitting in a shower chair in the company of Certified Nurse Aide #44. Water was filling up on the floor. Resident #8 fell while Certified Nurse Aide #44 was picking up dirty linen from the floor. The conclusion documented that the shower drain was clogged and the wheelchair should be brought to the bathroom when giving a shower. The statement provided by Certified Nurse Aide #44 documented (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335845	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Northeast Ctr for Rehabilitation and Brain Injury		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Grant Avenue Lake Katrine, NY 12449	
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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	that Resident #8 had a shower. After the shower they turned to get a towel and lotion at which time Resident #8 stood up out of the shower chair and fell. The nursing progress note dated 10/31/2025, written by Registered Nurse Unit Manager #31, documented Resident #8 sustained a fall with no injury while in the shower room with a certified nurse aide. The certified nurse aide reported that Resident #8 fell when they turned away from them to pick up dirty linen. Water was noted to be collecting on the floor of the bathroom. During a telephone interview on 06/10/2026 at 1:42 PM Registered Nurse Unit Manager #31 stated that they responded to the fall involving Resident #8 on 10/31/2025. They recalled that the resident was still on one-to-one at the time of the fall and a certified nurse aide was with the resident in the shower room. They stated that the floor had a lot of water accumulating on it and they had to page maintenance to repair the drain. The resident did not sustain an injury. 2) Resident #33's diagnoses included cerebral infarction due to thrombosis of basilar artery (a severe type of stroke where a blood clot blocks the main artery supplying blood to the brain), insomnia (common sleep disorder that makes it hard to fall asleep or stay asleep), and anxiety. The quarterly Minimum Data Set, dated [DATE] documented Resident #33 had moderate cognitive impairment, was dependent on toileting hygiene and transfers, required substantial/maximal assistance for bed mobility, was incontinent of bowel and bladder and had two or more falls since prior assessment with no injury and one with injury. A resident care plan titled Resident at risk for falls dated 07/10/2024 documented Resident #33 had a history of falls, difficulty in walking and flaccid hemiplegia (medical condition causing paralysis and very loose, floppy muscles on one side of the body) affecting unspecified side. Interventions included fall screen as per policy, remind to call for assistance as needed, bed to be in low position at all times, high profile floor mat to be placed on right side of bed while resident is in bed, ensure resident positioned in the middle of bed and feet not hanging off side of bed, resident will safely transfer from bed to floor/mattress and chair to floor mattress without injury and resident allowed to lay on floor/mat. A facility Accident and Incident Report dated 06/06/2025 at 11:58 AM documented Resident #33 sustained an unwitnessed fall from their bed. Staff discovered the resident lying face forward on the floor next to the bed. Resident #33 had been experiencing some vomiting before the fall but was unable to verbalize specifically what they were trying to do and where they were trying to go. Resident simply verbalized, I fell out of bed. The resident was evaluated by a licensed nurse, and the nurse practitioner was apprised. The resident also complained about some leg and back pain. After the evaluation was completed, the resident was assisted by a wheelchair. The resident was also noted to have scattered abrasions to their back. The resident received a skin check where abrasions were noted. The Nurse Practitioner was advised of the event and follow up x-rays were ordered which were negative for any fractures. Resident checked for pain. The immediate intervention and investigation summary documented the resident was assessed by a registered nurse. The resident plan of care was reviewed. All appropriate interventions to keep the resident safe in place. Upon (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335845	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Northeast Ctr for Rehabilitation and Brain Injury		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Grant Avenue Lake Katrine, NY 12449	
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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	further investigation and staff interviews, it was determined that the residents' bed was not in the lowest position and bilateral floor mats were not in place as care planned. The assigned certified nurse aide was immediately disciplined and suspended. A nursing note dated 06/06/2025 at 11:38 AM documented resident noted shouting from room. Upon entering, the nurse observed the resident on the floor parallel to bed, lying on their back. There was a skin tear to right elbow and right knee cap. Code Angel was called. The Registered Nurse Supervisor came to the unit to assess the resident. Open areas were cleansed with normal saline and covered with a border dressing. Resident#33 reported they fell out of bed. There was vomit on the sheets and the resident was assisted by two (2) staff via mechanical lift to the chair. The resident reported pain to their right knee, and the Nurse Practitioner was made aware. A nursing note dated 06/06/2025 at 11:58 AM documented they responded to Code Angel and Resident #33 was observed on their back on the floor next to their bed. Two skin tears were observed on right elbow, right wrist and a scrape was observed on the right knee. There was a moderate amount of emesis (vomit) on the bed and on the resident's chest. When the resident was asked what happened, they stated they fell out of bed. Resident #33 complained of neck, back and right leg pain. A Nurse Practitioner note dated 06/06/2025 at 2:00 PM documented an unwitnessed fall. Resident #33 was found on the floor on their back. Bed in low position. The resident had anxiety and did not listen to most of the staff. No serious injury noted, however directive given for x-ray of scrape on elbow. The plan was that neurological checks were initiated for the unwitnessed fall with no serious injury; encourage the resident to call for help when they need something; and X-rays of right elbow, right wrist, right hip, right knee and complete pelvis were ordered. There was no documented evidence that neurological checks were completed in the electronic medical record. A review of Resident #33's Resident Profile Care Card dated 06/17/2026 documented high profile floor mat to be placed on right side of the bed while resident in bed, maintain bed in lowest position, ensure resident positioned in middle of bed and feet not hanging off side of bed. Remind resident to call for assistance. Resident will safely transfer from bed to floor/mattress and chair to floor/mattress without injury and resident allowed to lay on floor/ mat. Floor mat to be place on right side of bed. Left side of bed against wall. Reinforce need for assistance with transfers despite perceived independence. During an interview on 06/09/2026 at 4:02 PM, the Director of Nursing stated they did not recall Resident #33's fall from 06/06/2025 as they had just started working at the facility. The Director of Nursing stated the resident care plan and profile care card interventions were expected to be reviewed and followed by facility nursing and certified nurse aide staff prior to providing cares. During an interview on 06/10/2026 at 8:45 pm, Certified Nurse Aide #39 stated they recalled the incident with Resident #33 from 06/06/2025 and believe it was their second day working on that unit. Certified Nurse Aide #39 stated the unit was very busy on 06/06/2025 and during the shift they were contacted by a Unit Manager from another unit who wanted them to complete documentation from a (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335845	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Northeast Ctr for Rehabilitation and Brain Injury		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Grant Avenue Lake Katrine, NY 12449	
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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	previous shift before they left the facility on [DATE]. They stated they had provided cares on Resident #33 a few minutes prior to notification. Certified Nurse Aide #39 stated they observed floor mats folded up next to the wall in Resident #33's room during cares and had raised Resident #33's bed to above knee level while providing the cares. They stated when they completed cares for Resident #33, they did not return the bed to the lowest level or place the floor mats next to the bed and became distracted by the request to complete documentation. Certified Nurse Aide #39 stated they became aware of Resident #33 falling when they heard Code Angel being called on the facility overhead speaker. They stated they were at the nursing station completing the requested documentation when they heard the code called. Certified Nurse Aide #39 stated they went to see where the Code Angel was on the unit, and a unit nurse informed them Resident #33 had fallen out of bed and that they had forgotten to put the bed in its lowest position or place mats at the bedside for Resident #33 after providing cares. Certified Nurse Aide #39 stated they did not check the resident profile care card on the electronic medical record and were not aware of care plan interventions for Resident #33 to have bed in lowest position and floor mats in place while the resident was in bed. They stated they had to complete documentation before they clocked out, were stressed over time and did not check back on Resident #33 after cares were completed. Certified Nurse Aide #39 stated when they entered Resident #33's room after the fall, they observed Resident #33 on the floor and that they had vomited. The Unit Manager and Nursing Supervisor were also present in the room. They stated they retrieved the Hoyer lift, and the Unit Manager and Nurse Supervisor transferred Resident #33 to their wheelchair. Certified Nurse Aide #39 stated they were sent home and did not complete their shift and did not return to employment at the facility. Certified Nurse Aide #39 stated they had worked at the facility for almost a year, had completed the facility Certified Nurse Aide training program in April 2025 and the facility was frequently understaffed which created a stressful work environment. During a brief interview on 06/11/2026, the Administrator stated certified nurse aides were expected to review patient profile care cards and be aware of interventions prior to providing cares. During an interview on 06/18/2026 at 11:17 AM, Nurse Practitioner #58 stated they evaluated Resident #33 after the 06/06/2025 fall and ordered an x-ray of right elbow which was negative for fracture. They stated the floor mats should have been placed at bedside and the bed in its lowest position after providing care as planned. They stated Resident #33 had a history of high anxiety, falls and non-compliance. Nurse Practitioner #58 stated Resident #33's unit had high acuity residents and there should have been more certified nurse aide staffing to ensure resident safety and care completion. They stated Certified Nurse Aide #39 should have been aware of care plan interventions/resident profile care card prior to providing cares and ensured bed was in lower position and floor mats in place prior to leaving the room after care completion. 3) Resident #35 had diagnoses including anoxic brain injury (occurs when brain is deprived of oxygen), post-traumatic seizure (sudden, abnormal bursts of electrical activity in the brain that happens after a head injury) and quadriplegia (paralysis causing partial or total loss of motor and sensory function in all four limbs and the torso). The facility policy titled Activities of Daily Living Care Plan last revised 06/2024 documented a program of activities of daily living (ADL) is provided to residents to return residents to a maximum level of independence. The ability of each resident to meet the demands of daily living is assessed by (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335845	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Northeast Ctr for Rehabilitation and Brain Injury		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Grant Avenue Lake Katrine, NY 12449	
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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	a registered nurse. Assistive devices and adaptive equipment are provided by occupation therapy services. The facility policy titled Functional Support Services last reviewed 12/2024 documented it is the facility policy to ensure safe resident transfers. The level of assistance, number of recommended staff and assistive device will be noted on the Kardex (certified nurse aide instructions in the electronic medical record), transferred from the Activities of Daily Living/Mobility Plan of Care. All mechanical assistance transfers must be completed with two people. The Annual Comprehensive Minimum Data Set, dated [DATE] documented Resident #35 was cognitively intact, dependent for activities of daily living and transfers and had no falls since last assessment. A care plan titled Impaired Activities of Daily Living Performance/Physical Mobility updated 10/18/2024 documented interventions including dependent and two-person assistance for bed mobility, chair/bed to chair transfers/Hoyer lift (mechanical lift device), and shower/bathing. The undated facility Major Investigative Summary documented upon initial assessment Registered Nurse Supervisor #51 responded to Code Angel (fall code) to find Resident #35 on the shower room floor, face down, arms tucked underneath torso. Resident #35's head was turned to the left with fresh blood on the floor around their head. The floor was wet. A team of staff log rolled Resident #35 onto their back with the head supported for alignment. Resident #35 denied pain. Physician #1 was notified and responded to send Resident #35 to hospital for evaluation and stitches. Resident #35 had sustained bruises on right hand knuckles and left wrist. Per Registered Nurse Supervisor #51's note, Resident #35 was being bathed in the shower room on a shower trolley. Certified Nurse Aide #38 had finished the front part of body and brought up the trolley rail to wash back side when the rail fell, and Resident #35 slipped off the trolley onto the floor. Resident #35 hit their head and had an open cut over their right eye and an abrasion noted to four knuckles on the right hand and left wrist. A telephone interview dated 12/13/2024 by Assistant Administrator with Certified Nurse Aide #38 documented Certified Nurse Aide #38 stated they were standing on the left side of the trolley with the resident's back towards them. They stated they had both side rails up and they walked around to the right side. Certified Nurse Aide #38 stated that they put both rails down so that the water could run off. They stated that they put the right side back up and turned Resident #35 on their side. They could not remember what side. They stated that Resident #35 went into what they described as a body spasm and slid and fell out of the trolley. They admitted to being the only staff member. They admitted not asking anyone for help. They stated they were a certified nurse aide for eight years and understood that any time there was a Hoyer lift and shower trolley, it required two-person assistance, and they failed to follow the care plan. A Resident Version Event Form dated 12/13/2024 and completed by Licensed Practical Nurse Unit Manager #27, documented Resident #35 was asked how the event on 12/12/2024 occurred. Resident #35 stated that the (certified nurse aide) made a mistake and dropped them. Resident #35 stated the side rail was not up. Resident #35 stated they thought they were turning to their left side when the event occurred. They stated the rail behind them was up and not the rail on the side they were facing. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335845	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Northeast Ctr for Rehabilitation and Brain Injury		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Grant Avenue Lake Katrine, NY 12449	
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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A nursing progress note dated 12/13/2024 at 9:46 AM, documented Resident #35 returned from hospital during the prior shift. Physician #1 in to see resident this morning. Nineteen stitches above right eyebrow, chin abrasion and right cheek, right knuckles with abrasions, left ankle with bruising outer aspect slight swelling. Physician would review x rays from hospital. Computed tomography (CT) scan of the head was negative. Resident had no complaints. Physician #1 stated keep eyebrow abrasion with stitches moist with bacitracin. Physician #1's progress note dated 12/14/2024 at 9:00 AM, documented fall, forehead laceration, left ankle contusion. Had mechanical failure of shower trolley, fell to floor, sustained contusions, and right forehead laceration. Sent to emergency room, sutured laceration with 19 sutures. Have received emergency room records and received left foot/ankle image. Head: right forehead sutured lacerations. Some continued bruising right knuckles, left ankle/foot with some bruising, pain on movement. Has foot drop bilateral. Action/Plan: continue wound care. Suture removal after five days. During an interview and observation on 06/09/2026 at 9:50 AM, Resident #35 stated on 12/12/2024, an aide presented to their room with a shower trolley and transferred them from the bed to shower trolley without a second person assisting. Resident #35 stated they did not question why there was not a second person because they had been transferred on other occasions by just one certified nurse aide. Resident #35 stated during the shower, side rails were up at times, but when the aide repositioned them on their right side they believed the rail gave way or may not have been up, and they fell off the shower trolley and landed on the floor. Resident #35 stated they did not recall having a seizure during the incident and they were sent to the emergency room where they received sutures on their right eyebrow. Resident #35 stated the unit was short staffed at times. During interviews and observations on 06/10/2026 at 10:52 AM and 06/18/2026 at 12:37 PM, the Director of Maintenance stated the shower trolley involved in the incident with Resident #35 was a metal style trolley from Manufacturer #1. During an observation of a Manufacturer #1 shower trolley, the bilateral side rails contained a box-type latch located near the head and foot on the underside on both sides of the trolley table. The Director of Maintenance demonstrated that the side rails needed to be lifted up until a clicking sound was heard. The clicking sound indicated the side rails were locked. They stated the rails should always be double checked by staff to ensure the side rails were locked in place. To unlock the side rails, the rails were lifted until unlatched and lowered. The Director of Maintenance demonstrated that if the upper or lower latch does not click into locking position, as long as one box latch was clicked into place, the rail will not drop down. The rails would only drop when lifted and the upper and lower boxes unlatch. The Director of Maintenance stated the only way a resident could roll off a shower trolley was if the staff or resident lifted and unlatched the rails or if the rails were not locked in place at all and left lowered. They stated if there was a concern with latch boxes under rails not working, the rail would not have been able to securely latch. The Director of Maintenance stated on the evening of the incident on 12/12/2024, the shower trolley was immediately taken out of service and removed from the unit and placed in the maintenance unit. When they presented to facility the next morning, they inspected the shower trolley. They stated they had no concerns with the shower trolley. The bilateral side rail box latches were observed and were in working condition. They stated they tested side rails by locking and unlocking and there were no concerns. They also tested the head and foot rails, and the shower trolley was in good working condition with no areas of concern. They stated they inspected all shower trolleys in the facility (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335845	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Northeast Ctr for Rehabilitation and Brain Injury		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Grant Avenue Lake Katrine, NY 12449	
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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	status post the incident and they were all found to be in good repair. The Director Maintenance stated they could not locate the annual facility inspection or other inspections of facility trolleys prior to their start of employment in October 2025. Manufacturer #1 user manual was reviewed with the Director of Maintenance which included a recommendation for an annual safety check to be completed by manufacturer. The Director of Maintenance stated this was not completed and all equipment safety checks were completed by facility staff only. During an interview on 06/10/2026 at 11:41 AM, Licensed Practical Nurse Unit Manager #27 stated they were present on the unit on 12/12/2024 when Resident #35 sustained a fall from a shower trolley. They stated Resident #35 had a care plan intervention for two-person assistance for bed mobility, transfers and showers which Certified Nurse Aide #38 did not follow. They were not aware if Certified Nurse Aide #38 requested assistance with cares from other unit staff on 12/12/2024. Licensed Practical Nurse Unit Manager #27 stated the incident was a care plan violation and Certified Nurse Aide #38 should have requested assistance which could have prevented the accident. They stated they were not aware of any concerns with the shower trolley prior to the incident on 12/12/2024. During an interview on 06/10/26 at 4:14 PM, the Administrator stated certified nurse aide staff should review resident profile care card on electronic medical record prior to completing tasks for task instruction/interventions. Facility certified nurse aide staff should be aware of care plan interventions including two-person assistance tasks and not complete such tasks without another staff member present. During an interview on 06/10/26 at 6:45 PM, Certified Nurse Aide #38 stated Resident #35 was dependent for showering and required two-person assistance due to using a shower trolley and Hoyer lift for transfers. They stated while showering Resident #35 on 12/12/2024, they had placed the right-side rail up to wash Resident #35's back and they were standing on the left side of shower trolley. They stated Resident #35 started to have tremors and shake which caused the right-side rail to unlatch and release and Resident #35 fell to the ground. They stated they believed it was the right side but could not recall definitively. Certified Nurse Aide #38 stated they did not notice any problems with the shower trolley or drain, and they checked the rails to ensure they were locked after raising. Certified Nurse Aide #38 stated they immediately called for the unit nurses to assist. They stated the facility nurse supervisor also responded to the shower room and assessed Resident #35 who was bleeding from the eyebrow area. Certified Nurse Aide #38 stated they worked at the facility through an agency and had worked on the unit prior to the incident as well as floating to other units. They stated 12/12/2024 was the first time they showered Resident #35. Certified Nurse Aide #38 stated the unit was very busy on the 12/12/2024 3:00 PM to 11:00 PM shift and they were assigned to shower duties. Certified Nurse Aide #38 stated they attempted to get another certified nurse aide to assist but the other three aides on the unit were busy on the other side of the unit and the nurses were also busy. They stated they did not report to unit nurse staff that they did not have another staff member to provide two-person assistance. Certified Nurse Aide #38 stated they transferred Resident #35 from their bed to shower trolley using the Hoyer lift, rolled the shower trolley to the shower room and showered Resident #35 without a two-person assist. They stated they did not wait to shower Resident #35 until staff were available to assist because they had other residents to shower and wanted to get the assigned showers completed. Certified Nurse Aide #38 stated they were unaware of (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335845	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Northeast Ctr for Rehabilitation and Brain Injury		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Grant Avenue Lake Katrine, NY 12449	
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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	care plan interventions and did not review the Profile Care Card (care instructions for direct care staff) for Resident #35 prior to transferring and showering Resident #35 on 12/12/2024. During an interview on 06/18/2026 at 1:06 PM, Physician #1 stated they assessed Resident #35 after the resident fell from a shower trolley on 12/12/2024 and they did not recall Resident #35 having a seizure during the incident. They stated Resident #35 was quadriplegic, had a hard fall from a high height from the shower trolley and sustained sutures to eyebrow as a result. Physician #1 stated when a resident required a two-person assist for Hoyer transfers and/or cares, the expectation was that two-persons provide the transfer/cares. Physician #1 stated the reason policies and interventions were put in place was to prevent the chance of injury to residents. Physician #1 stated they expected facility residents to be safe, receive cares and increase or maintain their abilities and independence to the extent possible. Physician #1 stated facility staffing levels and the use of agency aides who were not familiar with residents was concerning. They stated they had observed Hoyer transfers throughout the facility by two staff members and one staff member performing transferring and/or providing person care that required two staff was not an optimal situation. Physician #1 stated appropriate staffing levels need to be provided to maintain resident safety. 10 New York Codes, Rules and Regulations 415.12(h)(1)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335845	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Northeast Ctr for Rehabilitation and Brain Injury		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Grant Avenue Lake Katrine, NY 12449	
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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on interview and review of facility records during the abbreviated survey, the facility did not ensure consistent sufficient nursing staff was provided to meet the needs of residents on all shifts. Specifically, 1) See F677 for deficient practice in activities of daily living. 2) multiple complaints were received by the Department of Health that reported the facility was short staffed; 2) Several nursing staff reported there was lack of staff to provide all cares to the residents; 3) facility nursing staff sheets reviewed from 05/19/2026 to 06/13/2026 documented the facility did not staff multiple units at minimum levels daily and did not meet the daily projected staff needs for certified nurse aides and nursing staff as documented in the Facility Assessment for 26 of the 26 dates reviewed. 3) Actual nursing staff sheets for dates of complaints were reviewed and documented the facility was below the projected levels documented on the Facility Assessment. Findings include: The 2025 and 2026 Facility Assessment documented projected staff needs: Direct Care Certified Nurse Aides 26 full time days, 25 full-time evenings, 16 full-time nights. Cart Licensed Practical Nurses/Registered Nurses: 14 full-time days and evenings, 11 full-time nights. Unit Manager Licensed Practical Nurses/Registered Nurses: 4 full-time days. Nurse Supervisors: 5 full-time days/evening/nights, day into evening, night into day. Licensed Practical Nurse Supervisor: 1 full-time days. The April 2025 facility staffing sheets (when compared to the minimum staffing levels on the Facility Assessment) documented that on 04/04/2025 the facility lacked 3 certified nurse aides on the day shift and 3 certified nurse aides on the evening shift. On 04/05/2025, the facility lacked 5 certified nurse aides on the day shift and 3 certified nurse aides on the evening shift. On 04/06/2025, the facility lacked 2 certified nurse aides on the day shift and 7 certified nurse aides on the evening shift. On 04/12/2025, the facility lacked 7 certified nurse aides on the day shift and 4 certified nurse aides on the evening shift. On 04/13/2025, the facility lacked 8 certified nurse aides on the day shift and 4 certified nurse aides on the evening shift. On 04/19/2025, the facility lacked 3 nurses for the day shift, 4.5 certified nurse aides for the day shift and 5 certified nurse aides for the evening shift. On 04/20/2025 the facility lacked 5 certified nurse aides on the evening shift. On 04/26/2025, the facility lacked 7 certified nurse aides on the evening shift. On 04/27/2025, the facility lacked 3 certified nurse aides on the evening shift, The facility staffing sheets dated 01/22/2025, 03/05/2025, 05/18/2025, 11/01/2025, 11/11/2025, and 03/09/2026 were reviewed. The actual staffing for the 5 days reviewed was less than the projected staffing needs based on the Facility Assessment The facility staffing sheets from 05/19/2026 to 06/13/2026 documented actual staffing was less than projected staffing needs for 26 of the 26 days reviewed. During an interview on 06/10/2026 at 3:51 PM, Staffing Coordinator #1 stated that Unit NRP5 held 40 residents, and the unit was usually full. They stated that the unit usually had two nurses and four (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335845	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Northeast Ctr for Rehabilitation and Brain Injury		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Grant Avenue Lake Katrine, NY 12449	
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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	certified nurse aides. They stated that the minimum number of certified nurse aides for that unit was three and there had been times when they dropped down to two aides for 40 residents. They stated when there were two aides, they got 20 residents each. They stated that the nurses on the unit will help them get the job done. They stated that for the most part, they had adequate staffing. During an interview on 06/12/2026 at 3:00 PM Certified Nurse Aide # 65 stated they were taking care of 14 patients today. They stated that their unit was often staffed with three aides. They stated that call outs did not always get replaced. They stated that there were times when they dropped down to two aides on the unit and it happened mostly on the weekends. They stated with two aides, they did not get all the showers done. They stated that some residents required a two person assist for bathing, and if the two aides were showering a resident, that left no aides on the floor and was not safe. A review of unit staff sheets from 04/11/2026 through 04/14/2026 documented Resident #5's unit was below certified nurse aide PAR levels for the day and evening shift on 04/11/2026 and 04/12/2026. On 04/13/2026 the unit was below certified nurse aide PAR levels on all three shifts and on 04/14/2026, the day and evening shift were below PAR levels and one (1) of the two (2) certified nurse aides on the night shift worked until 5:30 AM instead of 7:00 AM, leaving just one certified nurse aide on unit from 5:30 AM to 7:00 AM. See F677. During an interview on 06/08/2026 at 3:10 PM Certified Nurse Aide #34 stated they frequently were unable to complete task documentation in the electronic medical record due to the workload of unit and not enough staff. They stated they provided cares but did not document. Certified Nurse Aide #34 stated they have been counselled by Unit Managers, had been written up for incomplete/missing documentation in the past and had received in-services regarding certified nurse aide documentation policy. During an interview on 06/08/2026 at 3:30 PM Licensed Practical Nurse Unit Manager #6 stated the unit had problems with certified nurse aide documentation completion. They stated staffing was a significant concern on the unit and that two certified nurse aides for evening and night shifts were not sufficient and hindered staff from completing cares and documentation. During a telephone interview on 06/08/2026 at 04:02 PM, Certified Nurse Aide #30 stated they were unable to complete documentation on many shifts over the past three (3) years working at the facility. They stated the unit was frequently understaffed with three (3) aides on day shift and sometimes only two (2). They stated the unit had a heavy acuity and many residents require two-person assistance. They stated there were unit staff who documented completing resident cares who had not, and they had been suspended three (3) times for reporting the aides who did not complete cares. They stated they tried to complete documentation every shift but needed to leave promptly at the end of their shift and frequently did not have time to complete documentation after providing cares. During interviews on 6/15/26 at 2:21 PM and 06/18/2026 at 1:18 PM, the Administrator stated that the facility assessment documented the same minimal numbers for both 2025 and 2026. The numbers did change based on the acuity and census changes, but the assessment reflected the minimum. The Administrator stated the facility did not always meet desired daily staffing levels. When levels were (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335845	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Northeast Ctr for Rehabilitation and Brain Injury		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Grant Avenue Lake Katrine, NY 12449	
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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	not met, supervisory staff, licensed practical nurses and ancillary staff were utilized to assist short-staffed units. When someone was pulled from ancillary staff to help on a unit, it was not always reflected on the staffing sheets. They stated they may have pulled staff to the units on the days that the staffing was short. They stated agency staff were used daily to fill in gaps in staffing and some of the same agency staff consistently work at the facility. They stated the cons of using agency staff were continuity of care and not being familiar with resident care needs. Therefore, every effort to request agencies to send certified nurse aides and nurses who had worked at the facility in the past was made. They stated the facility had a high acuity of brain injury and dementia residents and continuity of care was important. The Administrator stated they did not believe short staffing levels affected resident cares and cares were completed timely. During an interview on 06/17/2026 at 10:34 AM, Staffing Coordinator #2 stated facility units were staffed following PAR levels provided by Administration. They stated they frequently were unable to meet the desired staffing levels due to lack of available staff. When PAR levels were unable to be met, certified nurse aides were assigned to half shifts or less on various units in the facility to attempt to provide coverage. Staffing Coordinator #2 stated the ventilation; premier and medically complex units had the highest acuity and NRP5 has also increased in acuity. They stated Administration were made aware daily of units that were not fully staffed. They stated the facility had full-time, part-time and per diem aides and two staffing agencies also used daily to assist in meeting PAR levels for both certified nurse aides and licensed nursing staff. Staffing Coordinator #2 stated bonus programs were used to encourage licensed nurses and certified nurse aides to sign up for extra shifts. They stated staff call outs affected staffing daily and last-minute bonuses were used in an attempt to replace call outs. They stated certified nurse aides and licensed nurses had expressed concerns with low staffing on units and the evening, weekend and holiday shifts were the most challenging to fully staff. During an interview on 06/17/2026 at 1:46 PM, Registered Nurse Supervisor #51 stated the facility struggled with certified nurse aide and nursing staffing. They stated some units were frequently understaffed with evenings and weekends being the most concerning. They stated residents were changed and provided with activities of daily living cares, but cares might not be completed timely, and residents may be put back to bed instead of staying up. They stated the facility's physical location made staff hard to find and there was a great deal of competition in the area with a small pool of available staff. They stated the insufficient staffing affected residents. Registered Nurse Supervisor #51 stated the facility had a concern with pressure ulcers and residents were not turned and repositioned every two hours due to insufficient staffing. Some units did not have managers/charge nurses and no one to oversee certified nurse aides. They stated the facility assigned staff nurses and certified nurse aides to multiple units per shift to fill in staffing gaps and consistently utilized agency staff who did not know the residents which effected continuity of cares and documentation. During an interview on 06/17/2026 at 2:44 PM, Assistant Director of Nursing #1 stated that licensed and certified nurse aide staffing was difficult, and the facility needed more staff. They stated the facility met the minimum amount of certified nurse aide and licensed nursing staffing levels daily and resident cares were completed as best as possible. Assistant Director of Nursing #1 stated staff had reported concerns with short staffing to the Director of Nursing and Administrator and not meeting the (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335845	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Northeast Ctr for Rehabilitation and Brain Injury		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Grant Avenue Lake Katrine, NY 12449	
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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	desired unit staffing PAR levels affects resident care by burning out the staff and resident cares being delayed. They stated staffing remains a facility quality initiative. During an interview on 06/17/2026 at 3:13 PM, Registered Nurse Unit Manager #31 stated they managed two units with intense resident populations. They stated there were approximately 40 residents between the two units, many of which had behavioral concerns requiring a great amount of supervision. They stated there were behavioral concerns throughout the building, with younger and stronger residents, and multiple mental health concerns and many residents with histories of violence. They stated the units were staffed with one licensed nurse and one certified nurse aide on one unit and two certified nurse aides on the other unit. Registered Nurse Unit Manager #31 stated the units were frequently staffed with agency licensed practical nurses and certified nurse aides and documentation was frequently not completed including medication administration and fifteen-minute safety checks, especially during night shift. They stated they had discussed concerns with the Assistant Directors of Nursing and Director of Nursing many times. During an interview on 06/18/2026 at 11:48 AM, the Director of Nursing stated they oversaw staffing for the facility along with Assistant Directors of Nursing. They reviewed acuity and adjusted staffing as needed and the current PAR levels were determined by corporate staff and had been in place since they started employment at the facility in May 2025. The Director of Nursing stated they could adjust par levels upward on a unit if needed. The Director of Nursing stated the facility struggled to meet the current PAR levels daily with the evening shift and weekends being most difficult. They stated not meeting daily unit PAR levels affected residents and staff by adding a lot of stress. They stated cares such as changing/toileting, turning and positioning might be delayed and showers passed on to the next shift when unit staffing was short. The Director of Nursing stated the facility utilized staffing agencies and they were not aware if the use of agency staff affected resident cares. They stated one of the facility units did not have a unit manager nurse for approximately two months and the position was anticipated to be filled by the end of month. The Director of Nursing stated that when units were short staffed, the facility pulled staff from rehabilitation, administration and secretarial staff (many who are certified nurse aides) to assist in resident care completion during the day shift. During an interview on 06/18/2026 at 1:06 PM, Physician #1 stated they expect facility residents to be safe, receive care and increase or maintain their abilities and independence to the extent possible. Physician #1 stated facility staffing levels and the use of agency aides who were not familiar with residents was concerning. Physician #1 stated appropriate staffing levels need to be provided to maintain resident safety. During an interview on 07/01/2026 at 9:00AM, Certified Nurse Aide #76 stated that when they worked at the facility the staffing was always short. They spoke of the vent unit specifically and stated that they had only two nurses and two certified nurse aides on some shifts which was not safe staffing. They stated if you said anything or complained, the administration was retaliatory. 10 New York Codes, Rules and Regulations 415.13(A)(1) (i-iii)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335845	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Northeast Ctr for Rehabilitation and Brain Injury		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Grant Avenue Lake Katrine, NY 12449	
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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility did not ensure a clean and homelike environment or take reasonable measures to protect the belongings of residents. Specifically, 1) multiple observations were made of debris and soiled linens on the floors, sticky floors, odors, and walls in disrepair; and 2) personal items were not inventoried on admission for Resident #19 and #40. Findings include: 1) During an observation on 6/02/2026 at 11:18 AM, room [ROOM NUMBER] was cluttered with personal effects and open and unopened food products on one of the beds and the floor. The floor was sticky when walking on it from unknown substance. During an observation 6/03/2025 at 9:07 AM, one of the beds in shared room [ROOM NUMBER](B) was covered with food and personal items, and the floor was sticky. During an interview on 6/9/2026 at 10:00 AM, the Director of Housekeeping stated that the day shift was expected to go into rooms at least three times a day to ensure supplies were distributed and garbage was removed. During observation of all the items outside of the room the Director of Housekeeping stated that the rooms were in the process of being cleaned and that was why all of the items were in the corridor. They stated the floors did feel sticky and they would see how they were diluting the chemical in the water. During an observation on 6/9/2026 at 11:38 AM on Unit NRP5, room [ROOM NUMBER] had a dirty floor with debris and a dirty towel. room [ROOM NUMBER] had a cup on the floor with liquid spilling out of it. room [ROOM NUMBER] had a floor that was dirty with debris and sticky. room [ROOM NUMBER] had a floor that was dirty with debris. room [ROOM NUMBER] had a floor dirty with debris. A garbage can in the hallway outside of room [ROOM NUMBER] was wet on the bottom and leaked fluid onto the floor beneath it. There was also debris on the floor near the garbage storage bins in the hallway. A letter dated 06/11/2026 to the facility from Resident #40's family member documented there was medical debris all over the floor which was comparable to walking on fly paper. The family member documented Unit NRP5 was the most disgustingly filthy unit in the building. During an observation on 06/30/2026 at 11:45AM on the second floor outside of the administrative offices, there was an odor of urine. During an observation on 06/30/2026 at 12:06 PM the wall behind the sink next to room [ROOM NUMBER] was discolored and worn away. During an observation on 7/01/26 at 3:06PM on the NRP 5 Unit four residents were sitting in the common area. There was a soiled towel and food debris on floor. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335845	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Northeast Ctr for Rehabilitation and Brain Injury		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Grant Avenue Lake Katrine, NY 12449	
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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 07/02/2026 on the NRP2 Unit, the floors were visibly soiled, and it was sticky in hallway outside room [ROOM NUMBER]. There was also a bag of soiled linen in the hallway directly on the floor. During an observation on 07/01/2026 at 1:41PM on the NRP 2 Unit in the room across from room [ROOM NUMBER], soiled linens were on the floor in the room as well as an empty soda bottle and papers. During an interview on 07/01/2026 at 2:32PM, a family/resident representative stated that the NRP 5 unit was filthy and poorly kept. They stated they did file a grievance about the cleanliness of the unit and Resident #40 has since moved to another unit. During an observation and interview on 7/21/26 at 10:57 AM, room [ROOM NUMBER]-412 had a wet adult brief on the floor by door. Resident #63 stated there was no garbage in the room because their roommate was forgetful and would throw sheets and clothing away. Resident #63 stated housekeeping did check for garbage every day or every other day. The bedside tables on the unit had dried food on them. There was no housekeeping staff to interview at this time. During an observation on 07/21/2026 at 11:15 AM, Resident #50's floor was sticky to walk on, the feeding tube pole/pump had dried formula stuck to it, and the top drawer of their dresser contained a used feed tube syringe stored in its bag with dried medication or mold. During an interview on 07/21/2026 at 11:20 AM, Unit Manager Registered Nurse #41 stated they had certified nurse aides to clean out resident dresser drawers, but they have not had enough staff to do that in a while. Housekeeping was responsible for cleaning the tube feeding poles. During an interview on 07/21/2026 at 11:35 AM, Housekeeping Aide #155 stated they had one housekeeper per unit. They cleaned the shower room, bathroom, common area, and then each resident room every day. The Director of Housekeeping was aware of the sticky floors and Housekeeping Aide #155 was told to use hot water to mop the floors. During an interview on 07/21/2026 at 11:49 AM, the Housekeeping Director stated they were aware of the sticky floors in some areas. They stated the waxed floors were reacting with a chemical to make the floor sticky. They were meeting with the Administrator daily to develop the action plan for the floors and address the worst areas first. There were plans to scrub and re-coat the floors, and some rooms may need to be stripped. The NRP5 Unit had been a challenge with frequent urination on the floor. 2) Resident #19 had diagnoses including anoxic brain damage (caused by lack of oxygen), cardiovascular accident (stroke) and quadriplegia. The admission Minimum Data Set (assessment tool) dated 06/12/2025, documented Resident #19's cognition was moderately impaired. Resident #19 required substantial to maximal assistance for upper body dressing and was dependent on staff for lower body dressing. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335845	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Northeast Ctr for Rehabilitation and Brain Injury		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Grant Avenue Lake Katrine, NY 12449	
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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no list of personal item upon admission in the resident's electronic medical record. During a phone interview on 06/04/2026 at 11:14 AM, the resident's family member stated they did the resident's laundry and had 2 signs up in the room. They told Social Worker #16 that they were missing a dozen shorts and tee shirts, and 20 pairs of socks. They stated they also told Social Worker #16 about a missing electric razor. They stated they were reimbursed for the razor but not for the clothing. During an interview on 06/04/2026 at 12:38 PM, Social Worker #16 stated the resident's family member brought in new clothes, and they wanted to do Resident #19's laundry and they put signs up. Social Worker #16 stated they suggested to have the clothes labeled and the family member ignored the suggestion. They stated the facility would take care of labeling by putting the clothes in a bag, writing a list and taking it to laundry. They stated they would not know the family member brought in new clothes until they complained about them missing. They stated they were not sure if they completed a grievance form for the family member when the clothes were reported missing. They stated the family member did not give specifics only that the resident wore extra-large tee shirts and pajama bottoms. Social Worker #16 stated they checked the laundry and a closet where they put unlabeled items that had been found. The social worker stated it was their responsibility to do a personal items list on admission. They reviewed the resident's electronic medical record and stated they could not find a list on admission and they found two lists of the resident's belongings dated 11/26/2025 and 03/16/2026. 3) During an interview on 07/01/2026 at 2:32PM, a family/resident representative stated a missing blanket was recently found but they were still looking for Resident #40's slippers. They stated there was no inventory taken when Resident #40 was admitted . During an interview on 07/02/2026 at 10:52AM the Director of Social Work stated that on admission all personal belongings should be logged in by nursing. It could also be completed by social work. Once the inventory was completed, it should have been put in the medical record and updated as needed. They stated Resident #40 did not have an inventory of personal belongings completed and were uncertain as to why it was not completed. During an interview on 07/02/2026 at 11:17AM, Social Worker #16 stated that personal items were inventoried on admission. They stated that very often the social worker would do it, nursing did not always complete them because of limited time. They stated there was no current Unit Manager on their unit to check. They stated they did not routinely check for the inventory if a resident transferred to their unit from another unit. When asked if Resident #40 had an inventory, they looked and stated they did not. They also looked at Resident #9 and stated they too were missing an inventory as well and it should be completed. 10 New York Codes, Rules and Regulations 415.5(h)(2)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335845	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Northeast Ctr for Rehabilitation and Brain Injury		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Grant Avenue Lake Katrine, NY 12449	
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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews conducted during the abbreviated survey, the facility did not ensure that injuries of unknown origin and unwitnessed falls were investigated thoroughly for two (2) of nine (9) residents (Residents #45 and #46) reviewed for accidents. Specifically, 1) Resident #45 was assessed to have leg pain, sent to hospital for evaluation, and diagnosed with a hip fracture. A thorough investigation was not completed to determine the cause of the fracture and rule out abuse; and 2) Resident #46 sustained an unwitnessed fall on 01/22/2025 and was discovered in the bathroom pulseless and cyanotic. A code was called, and the resident was transferred to the hospital. There was no documented evidence of an accident and incident report or investigation for the unwitnessed fall. Findings include: 1) Resident #45 had diagnoses that included Lewy Body Dementia, Parkinson's Disease and Major Depression. The admission Minimum Data Set assessment dated [DATE] documented moderately impaired cognition, set up assistance with eating, toileting hygiene with staff supervision, and ambulated with staff supervision, frequently incontinent of bladder and always continent of bowel. A review of the facility Accident and Incident reports from 11/19/2024 to 12/13/2024 documented the resident had falls on 11/16/24, 11/23/24, 12/3/24, 12/4/24, 12/6/24 and 12/7/24. The facility Accident and Incident report dated 12/13/2024 documented the Certified Nurse Aide reported Resident#45 complained of hip pain and was unable to move left leg. Left foot was externally rotated and recoiled when left hip was touched. The report documented the resident was sent to the hospital. On the same Accident and Incident report, the area below the accident description was titled Review for Potential Abuse/Neglect. The facility documented the accident did not result in harm to the resident and for the question which asked was there reasonable concern that appropriate action or inaction on the part of staff or others resulted in harm was answered no. The Certified Nurse Aide involved in the care of the resident submitted a statement which documented they went to change the resident and tried to get them washed up and dressed. They washed the resident's leg then came out and told the nurse the resident was in pain. A nurses note dated 12/13/2024 12:37PM documented the Assistant Director of Nursing#1 called emergency room and spoke with nurse who stated the resident was being admitted with comminuted left intertrochanteric fracture. The facility provided a second investigative report about the incident which documented the resident had a history of falls and it was determined when they went out to the hospital, they sustained a (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335845	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Northeast Ctr for Rehabilitation and Brain Injury		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Grant Avenue Lake Katrine, NY 12449	
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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	fractured hip. The resident was interviewed and denied abuse or mistreatment by anyone on staff. There was no documented evidence that an injury of unknown origin was conducted including a look back to determine how the injury occurred to rule out abuse. The Certified Nurse Aide statement was the only statement from the incident provided for review. During an interview on 7/1/26 at 12:46PM the Administrative Licensed Practical Nurse stated this was one of the first reports they did in the Quality Assurance role and did not think about injury of unknown origin but should have looked at it a little closer. They stated they fill out the Abuse section of the report before they were aware of the fracture but did but did not change it in the report. They stated the resident had moderate cognitive impairment (a Brief Interview for Mental Status score of 10) but asked the resident if they were abused by anyone and the resident told them no, so they went with that and documented there was no abuse. They were asked if they then asked the resident how the injury occurred, and they stated they did not ask because the resident was confused and was not able to recount what happened. They stated they did not determine how the fracture happened or do a 72 hr look back with staff interviews. During an interview on 7/2/2026 at 2:32PM the Administrator stated the resident was alert oriented and should have been asked about what happened and there should have been a look back to last three days to determine the true cause of the fracture. They stated there was no documentation in the resident record or in the facility report how the injury happened and can see that now. They stated they determined it was from all the falls but there was no investigation into the incident and they should have done a better job to find out what the cause of the accident was. 2) Resident #46 had diagnoses that included anoxic brain injury (caused by lack of oxygen), tracheostomy (opening in front of neck with tube for breathing), and malignant neoplasm (cancer) of the head, face, and neck. The Significant Change Minimum Data Set assessment dated [DATE] documented severely impaired cognition, behaviors including rejection of care daily, moderate assistance with ambulation, continent of bladder and occasionally incontinent of bowel, medications including antipsychotic, anticoagulant, and anticonvulsant, special treatments including oxygen therapy, suction, and tracheostomy care. The Nursing Supervisor's note dated 01/22/2025 documented that they responded to a Code Blue (an alert signaling a life-threatening medical crisis, most commonly when a patient's heart or breathing has stopped). It was reported to them that Resident #46 was discovered on the bathroom floor with the door closed and the water running. Cardiopulmonary resuscitation was initiated and automatic external defibrillator applied with asystole (cessation of cardiac activity) response, no charges from defibrillator. Intravenous attempted with no success. Airway established, pupils fixed and dilated. The respiratory note dated 01/22/2025 documented that they responded to a Code Blue at approximately 1:25PM, resident on the floor of bathroom, with tracheostomy out, no spontaneous vitals present. Cardiopulmonary resuscitation started, new #6 cuffed blue select trach inserted without issue, cuff inflated, artificial manual breathing unit on 100% oxygen with no resistance. Defibrillator pads placed, no shock advised multiple times, cardiopulmonary resuscitation continued (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335845	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Northeast Ctr for Rehabilitation and Brain Injury		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Grant Avenue Lake Katrine, NY 12449	
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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	until emergency medical services arrived. Intravenous access obtained by emergency medical services, normal saline and medications administered. Scant secretions suctioned from airway. Heart rate returned at approximately 1:58 PM after multiple medications were administered. Transferred by emergency medical services to hospital at approximately 2:00 PM. Concierge #75's statement dated 01/22/2025 was provided and documented that Concierge #75 last saw Resident # 46 on the unit in the common area at 1:15PM and had no observed concerns. There was no documented evidence of an accident and incident report, additional statements, or an investigation of the events leading to the fall on 01/22/2025. During an interview on 07/01/2026 at 11:33 AM, Concierge #75 stated that they did remember the day the incident occurred and remembered writing a statement. They disagreed with the time that was documented on the statement. They stated they did not see Resident #46 at 1:15 PM but rather on the morning of 01/22/2025 after morning report at approximately 10:00 AM. At 10:00AM they had no observed concerns. They were on break when the code was called and remembered when they returned and were entering the building, they observed the ambulance in front of the building and found out what happened. During an interview on 07/01/2026 at 12:47 PM, the Assistant Director of Nursing #1 stated that they would have expected an incident report and investigation completed for the unwitnessed fall on 01/22/2025. They were uncertain why there was no documented evidence of one. During an interview on 07/02/2026 at 2:35 PM, the Administrator stated they remembered the incident involving Resident #46 on 01/22/2025. They stated an incident report, and investigation should have been completed and they were uncertain why there was only one statement related to the event. 10 New York Codes, Rules and Regulations 415.4 (b)(3)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335845	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Northeast Ctr for Rehabilitation and Brain Injury		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Grant Avenue Lake Katrine, NY 12449	
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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews conducted during the abbreviated survey NY3005545 from 06/02/2026 to 06/16/2026, the facility did not ensure each resident who was unable to carry out activities of daily living received the necessary care and services for five (5) of 13 residents (Resident #5, #7, #11, #37, and #50) reviewed for Activities of Daily Living. Specifically, 1) Resident #11 had multiple observations of a scaly scalp and dandruff flakes observed on clothing and bilateral long, dirty and jagged fingernails. 2) During a review of Resident #5's certified nurse aide task completion documentation there was missing or no documented evidence that Resident #5 received turning and positioning or toileting cares as per resident care plan throughout shifts for dates ranging from 04/12/2026 through 04/14/2026. 3) Resident #7 had two (2) opportunities of documented evidence in the Nursing Treatment Administration Records that mouth care was consistently provided as ordered, every four hours; 4) Resident #37 had no documented shower/bathing during their two (2) week admission and 5) Resident #50 was observed of multiple occasions sweaty and there was no documented evidence showers were provided twice weekly as scheduled. The findings included: A facility policy titled Activities of Daily Living, last reviewed 05/2024 documented a program of activities of daily living (ADL) is provided to residents in order to return residents to a maximum level of independence. A facility policy titled Certified Nurse Aide Documentation last reviewed 01/2025 documented it is the policy of the facility to document resident daily care. To ensure continuity of care, regardless of the caregiver, through information and recording system that is resident specific, it is the certified nurse aide responsibility to review the Profile Care Card. The certified nurse aide must document care of the resident and complete before the end of their shift. The unit nurse is responsible for ensuring certified nurse aide documentation is completed. 1) Resident #11's diagnoses included nontraumatic intracerebral hemorrhage in brain stem, xerosis cutis, and need for assistance with personal care. The Comprehensive Minimum Data Set (a resident assessment tool) dated 03/06/2026 documented Resident #11 was cognitively intact, required set up/clean up assistance for eating and personal hygiene, substantial/maximal assistance for toileting hygiene, supervision/touching assistance for bed mobility, was dependent for transfers, had an external catheter and was frequently incontinent bowel and bladder. A physician order dated 04/23/2026 documented weekly skin checks and shower on Tuesday evening shift . There was no physician order observed for anti-dandruff shampoo. A resident care plan titled Activities of Daily Living Function dated 09/20/2023 documented (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335845	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Northeast Ctr for Rehabilitation and Brain Injury		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Grant Avenue Lake Katrine, NY 12449	
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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interventions including introduce self and explain procedures. Provide partial and total care with bathing. Provide positive reinforcement for efforts/achievements. Ensure clothes are clean and in good repair. Assist with combing hair. Monitor cleaning and condition of nails according to resident's ability. A review of the Certified Nurse Aide Resident Profile Care Card dated 6/08/2026 documented shower evening shift Tuesday and Saturday. Resident prefers showers. Provide nail care as desired by resident with bathing. Report to nurse if resident refuses personal hygiene or bathing. Observe skin condition while providing care. Assure fingernails are trimmed and filed. During an observation on 06/02/2026 at 10:39 AM, Resident #11 was in bed eating breakfast. Resident #11 was wearing a red long-sleeved sweater with dandruff flakes on the top neck and shoulder area. Resident #11's bilateral fingernails were long, jagged and dirty. Resident's #11 top center scalp area was caked with dandruff. During an observation on 06/02/2026 at 3:01 PM Resident #11 was seated in wheelchair with lunch tray present. Dandruff flakes were present on the arms, front and back upper shoulder, and neck area of red t-shirt Resident #11 was wearing and throughout the middle and center of scalp. Bilateral fingernails were observed long, jagged and dirty. During an observation and brief interview on 06/03/2026 at 10:46 AM, Resident #11 was observed in wheelchair wearing a black t-shirt with dandruff flakes and on front and back upper arm, shoulder and neck areas. Resident #11 stated they were not showered on 06/02/2026 and they were provided with a bed bath instead and received a bed bath earlier on 06/03/2026. They stated they could not recall if they refused a shower on 06/02/2026. Resident #11 stated they refuse showers sometimes and they could not explain why. Resident 11's hair was groomed and parted in the middle. Caked dandruff was present throughout the middle part and crown area of scalp. Resident #11 stated they were unaware if an anti-dandruff shampoo was used during showers/hair cares. Resident 11's bilateral fingernails were long, jagged and dirty. Resident #11 stated they could not recall if staff offer to trim or clean nails. During an interview on 06/03/26 at 1:39 PM, Nurse Practitioner #10 stated they have not received reports from facility staff or family regarding cradle cap or dandruff. They stated they did not observe Resident 11's scalp during last visit on 05/29/2026 due to Resident #11 being reclined in bed during visit. During an observation and interview on 06/03/26 at 4:37, Certified Nurse Aide # 14 was observed providing cares to Resident #11. Certified Nurse Aide #15 was assisting. Certified Nurse Aide #14 stated Resident #11 used [NAME] Spring and Old Spice soap which was supplied by family on body and hair when showered. They stated they were aware that Resident #11 had dandruff and that it was just the way their skin is. They stated Resident #11 had dandruff flakes throughout the top front portion of the grey sweatpants Resident #11 was wearing. Certified Nurse Aide #14 stated Resident 11's scalp was always flaky, and they have not reported to unit nurse staff. They stated Resident #11 frequently refuses shower and bed bathes were provided during refusals. Certified Nurse Aide #14 stated during bed bathes they wash Resident #11's hair with a wet washcloth and a no rinse soap. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335845	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Northeast Ctr for Rehabilitation and Brain Injury		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Grant Avenue Lake Katrine, NY 12449	
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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	They stated Resident #11 nails were long, jagged and dirty and stated Resident #11 does not allow their nails to be cut, and they wash hands and nails with a washcloth. Certified Nurse Aide #14 stated they have not reported nail cutting/care refusals to unit staff nurses. During an observation and interview on 06/03/2026 at 4:53 PM, Licensed Practical Nurse Unit Manager #6 stated there was thick, scaly dandruff present on Resident #11's scalp. They stated they were not aware that Resident #11 had dandruff, and the unit certified nurse aide staff had not reported concern. Licensed Practical Nurse Unit Manager #6 stated they round the unit residents daily but do not assess residents as that was a registered nurse task. Licensed Practical Nurse Unit Manager #6 stated Resident 11's fingernails were long, jagged and dirty. During the observation, Licensed Practical Nurse Unit Manager #6 asked Resident #11 if they would allow nails to be cut and cleaned and Resident #11 replied yes. Licensed Practical Nurse Unit Manager #6 stated Resident #11 frequently refuses shower and has a rejection of cares care plan in place. They stated Resident #11 will accept a bed bath as an alternative to showering frequently and will shower about once a week. During an interview on 06/09/2026 at 8:38 AM, the Director of Nursing stated the facility expectation was that all refusal of cares and resident concerns were discussed with the nurse/unit manager by certified nurse aide staff and the physician notified if applicable. 2) Resident #5's diagnoses included cerebral infarction due to unspecified occlusion or stenosis of the right middle cerebral artery, hemiplegia and hemiparesis following cerebral infarction affecting left dominant side and restlessness and agitation. The Comprehensive Quarterly Minimum Data set (a resident assessment tool) dated 03/02/2026 documented Resident #5 had moderate cognitive impairment, behaviors that significantly interfere with the resident's care and disrupts care, rejects cares, was dependent for all cares and transfers and was incontinent of bowel and bladder. A physician order dated 04/29/2026 documented preventative skin care order. Turn and position. A resident care plan titled Activities of Daily Living and Mobility last updated 06/02/2026 documented interventions including turning and positioning every two (2) to three (3) hours, check and change every two to three hours and as needed, ensure clothes are clean and in good repair, monitor for presence of pain/intolerance during movement and allow increased time to complete tasks. A resident care plan titled alteration in bowel status/function dated 02/24/2026 documented interventions including monitor bowel status and record every shift and update physician as needed. A nursing note dated 04/13/2026 documented Resident #5 was seen for wound rounds with Nurse Practitioner and treatments completed by wound care team. There were no other documented nursing notes from 04/12/2026 through 04/15/2026. A review of the Treatment Administration Record from 04/11/2026 through 04/15/2026 documented monitoring/increase supervision and monitoring for combative behaviors was documented every shift. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335845	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Northeast Ctr for Rehabilitation and Brain Injury		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Grant Avenue Lake Katrine, NY 12449	
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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Certified Nurse Aide Resident Profile Card dated 06/12/2026 documented toileting hygiene check and change every two (2) to three (3) hours and as needed, two floor mats and turn and position every two (2) to three (3) hours. A review of the Certified Nurse Aide Task Completion Record from 3:00 PM on 04/12/2026 through 9:00 PM on 04/14/2026 revealed there was no documentation of certified nurse aide cares from 11:00 PM on 04/12/2026 through 11:00 PM on 04/13/2026. On 4/13/2026, Resident #5 was documented positioned on back at 11:00 PM, 1:00 AM, 3:00 AM, and 5:00 AM. Toileting was documented at 5:00 AM only. There was no documentation of certified nurse aide cares from 5:00 AM on 04/14/2026 through 9:00 pm on 04/14/2026. During an interview on 06/08/2026 at 01:15 PM, the Assistant Administrator stated they were unable to provide certified nurse aide documentation for the 11:00 PM to 7:00 AM shift starting at 11:00 PM on 04/12/2026 and the 7:00 AM-3:00 PM and 3:00 PM to 11:00 PM shifts on 04/13/2026. They stated the certified nurse aides assigned to Resident #5 did not complete documentation for these shifts. They stated when tasks not documented, they cannot be confirmed as completed. During an interview on 06/08/26 at 3:10 PM. Certified Nurse Aide #34 stated they were assigned to Resident #5 on 04/12/2026 from 3:00 PM to 11:00 PM and they were aware they did not document all tasks as completed for the shift. They stated they frequently were unable to complete task documentation in the electronic medical record due to workload of unit and not enough staff. They stated they could not remember specifically why they were unable to document tasks on 04/12/2026. They stated they provided cares but did not document. They stated they did recall that Resident #5 had a roommate who had a 1:1 sitter present. They stated they have been counselled by Unit Managers, have been written up for incomplete/missing documentation in the past and have received in-services regarding certified nurse aide documentation policy. During an interview on 06/08/2026 at 3:30 PM Licensed Practical Nurse Unit Manager #6 stated the unit has problems with certified nurse aide documentation completion. They stated they have been the unit manager for approximately two (2) months and have been reviewing certified nurse aide documentation and discovered there was substantial missing certified nurse aide documentation. They stated they have reported concern to Assistant Director of Nursing. During a review of Resident #5's electronic medical record, Licensed Practical Nurse Unit Manager #6 stated certified nurse aide task documentation was not complete or entirely missing for shifts 04/12/2026 through 04/14/2026. They stated they were not informed by staff that Resident #5 did not receive cares during any shift, and they round unit at 8:00 AM each morning. They did not recall observations of Resident #5 being soiled or not provided with cares. They stated staffing was a significant concern on the unit and that two certified nurse aides for evening and night shifts were not sufficient and hinders staff from completing cares and documentation. During a telephone interview on 06/08/2026 at 04:02 PM, Certified Nurse Aide #30 stated they usually work from 6:00 AM to 2:00 PM and may have worked with Resident #5 on 04/13/2026 but could not recall. They stated they were unable to complete documentation on 04/13/2026 and many other shifts over the past three (3) years working at the facility. They stated the unit was frequently understaffed with three aides on day shift and sometimes only two (2). They stated the unit has a heavy acuity and (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335845	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Northeast Ctr for Rehabilitation and Brain Injury		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Grant Avenue Lake Katrine, NY 12449	
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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	many residents require two-person assistance, including Resident #5. They stated there were unit staff who document completing resident cares who have not, and they have been suspended three (3) times for reporting the aides who do not complete cares. They stated they try to complete documentation every shift but have to leave promptly at the end of their shift and frequently do not have time to complete documentation after providing cares. During a telephone interview on 06/08/2026 at 4:33 PM, Certified Nurse Aide #35 stated they usually work the 3:00 PM to 11:00 PM shift and have frequently provided or assisted with cares for Resident #5. They stated there have been shifts when they were not able to complete tasks or document tasks on the electronic medical record due to workload. They stated sometimes they can only document a couple of tasks such as bowel movements or eating. They stated they usually just assist another aide with Resident #5 and could not recall if they were assigned as primary certified nurse aide for Resident #5 during shifts in April 2026. During an interview on 06/08/2026 at 6:26 PM, Certified Nurse Aide #36 stated they work the 11:00 PM to 7:00 PM shift. They stated they document resident task completions on the electronic medical record about 2:00 AM and at the end of their shift. They stated they do not recall if they were assigned Resident #5 on 04/12/2026 or 04/13/2026 or if they assisted another aide for two-person assist cares. They stated there were shifts when they are unable to enter documentation due to workload. During a telephone interview on 06/08/2026 at 6:46 PM, Certified Nurse Aide #37 stated they were working as a 1:1 sitter on 4/12/2026 from 7:00 PM to 7:00 AM and 04/13/2026 from 3:00 PM to 7:00 AM for the roommate of Resident #5. They stated on 04/12/2026, Resident #5 did not receive certified nurse aide toileting cares and was not turned and repositioned until 6: 00 AM. They stated on 04/13/2026, Resident #5's family member requested Resident #5 be placed in bed at 5:00 PM. They stated Resident #5 was placed into bed and did not receive certified nurse aide cares again until they alerted the Unit Manager at 5:30 AM that Resident #5 had not received cares since 5:00 PM on 04/12/2026. They stated they had looked in on Resident #5 at about 5:30 AM before alerting Unit Manager and noticed Resident #5 had their feet hanging off the bed, was soiled with feces and urine and did not have floor mats at proper bedside positioning. They stated when they alerted the Unit Manager that Resident #5 had not received cares all night, two aides presented to the room and provided cares to Resident #5. They stated they could not recall who the aides were who provided cares on 04/12/2026 or 04/13/2026 as they had the curtains closed. They stated they did not hear Resident #5 trying to call for cares on 04/12/2026 or 04/13/2206 during shifts. During an interview on 06/09/2026 at 8:38 AM, the Director of Nursing stated certified nurse aide staff were expected to document cares provided to residents as close to the cares being rendered as possible or at least by the end of the shift. They stated certified nurse aide documentation was a facility concern that has required on-going training and teaching of certified nurse aide staff. They stated the facility has high acuity residents and the certified nurse aides were frequently so busy providing cares that they do not have time to complete required documentation of tasks/cares. The Director of Nursing stated certified nurse aide documentation in-services were on-going throughout the year and as needed. They stated unit managers nursing staff were responsible for ensuring completed documentation and unit managers have discussed the documentation concerns with them. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335845	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Northeast Ctr for Rehabilitation and Brain Injury		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Grant Avenue Lake Katrine, NY 12449	
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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Director of Nursing stated when documentation was observed missing/incomplete, the certified nurse aide was to be notified by the unit manager and requested to complete the documentation. During a telephone interview on 06/09/2026 at 8:59 AM, Licensed Practical Nurse #48 stated they worked 11:00 PM to 7:00 AM and were familiar with Resident #5. They stated the unit has a high acuity and not enough staff. Licensed Practical Nurse #48 stated they always ensured Resident #5 received cares including toileting checks/cares as needed and repositioning every two hours. They stated they were aware that there were times when certified nurse aide care documentation was not completed. They stated the high acuity and workload of unit makes time an issue. Licensed Practical Nurse #48 stated they did not recall nights when a staff member reported resident had not received cares or had legs hanging out of bed. They stated Certified Nurse Aide #47 was usually primary certified nurse aide assigned to Resident #5 during 11:00 PM to 7:00 AM shift. They did not receive complaints from day shift that cares were not completed during the night. They stated they would assist certified nurse aides with tasks when needed and would also try to complete there cares such as medication administration at the same time for Resident #5 due to combative concerns with Resident #5 while they were on unit. During an interview on 06/09/2026 at 1:57 PM, Certified Nurse Aide #46 stated they have been assigned to provide cares for Resident #5 in the past and have frequently assisted other certified nurse aides with cares for Resident #5. They stated they must not have been assigned as primary certified nurse aide on 04/12/2026 through 04/13/2026 because cares would have been documented. They stated there have been occasions where they might not document all cares, but they always document some completed tasks. They stated they frequently presented to the unit to start shift at 7:00 AM and found Resident #5 soiled and wet, with legs sometimes hanging out of bed. They stated they always reported to the unit manager/nurse on duty when this occurred. During a telephone interview on 06/12/2026 at 12:30 PM, Certified Nurse Aide #47 stated they work the 11:00 PM to 7:00 AM shift on unit and were frequently assigned Resident #5. They stated they would turn and position and provide toilet checks/cares if needed every two hours for Resident #5. They stated Resident #5's pillows would be readjusted from side to side during repositioning and resident was not completely positioned on side due to history of falling out of bed. They stated floor mats were always in place bilaterally. Certified Nurse Aide #47 stated they only document what was prompted to document on the electronic medical record and do not document extra toileting or positioning and always complete documentation and cares by the end of shift. They stated they may have only documented toileting at 5:00 AM on 04/13/2026 if that was the only prompt provided. They stated they were not working at facility the night of 04/12/2026 but was present on 04/13/2026. Certified Nurse Aide #47 stated unit frequently one has one certified nurse aide and one licensed practical nurse to care for forty residents during night shift. 3) The facility policy titled, Activity of Daily Living reviewed 05/2024 documented a program of activities of daily living is provided to residents in order to return residents to a maximum level of independence. The responsible disciplines of Registered Nurse, Licensed Practical Nurse, and Certified Nurse Aide provide good oral hygiene. Resident #7 was admitted with diagnoses including but not limited to Cerebellar stroke syndrome, (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335845	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Northeast Ctr for Rehabilitation and Brain Injury		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Grant Avenue Lake Katrine, NY 12449	
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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dysphagia, and need for assistance with personal care. The admission Minimum Data Set (resident assessment tool) dated 04/08/2026 documented Resident #7 had intact cognition, nothing by mouth, and required maximal assistance for oral hygiene. There was no current Dental Care Plan but a discontinued Dental Care Plan documented potential for oral health problems with interventions to provide oral hygiene every shift and as needed, dental evaluation yearly and as needed, notify physician of all variances, and medications as ordered. The physician order titled Enteral Protocol /Mouth care dated 04/03/2026 documented mouth care every four hours and as needed. The Treatment Administration Record for the month of April 2026 documented Mouth care, every four (4) hours and as needed. There were only two (2) documented dates and times of care provided: 04/05/2026 at 1 PM and 5 PM. The rest of the month was blank. During an interview on 06/03/2026 at 1:12 PM Licensed Practical Nurse, Unit Manager #6 stated the order for mouth care was every four hours and would use mouth swabs. They recalled seeing it on the treatment record when they worked the cart. They were not sure why the treatment record only had two (2) opportunities documented. During an interview on 6/4/26 at 2:07 PM the Assistant Director of Nursing stated it looked like the order was started on 04/05/2026 and then discontinued the same day and was not reinstated. Potentially Resident #7 did not receive mouth cares from 04/05/2026 through 05/05/2026 when they were discharged to the hospital. 10 New York Codes, Rules, and Regulations 415.12(a)(2)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335845	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Northeast Ctr for Rehabilitation and Brain Injury		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Grant Avenue Lake Katrine, NY 12449	
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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews conducted during the abbreviated survey, the facility did not ensure that necessary care was provided to ensure the administration of tube feeding according to established criteria for accuracy and prevention of complications for three (3) (Residents #50, #61 and #62) of seven (7) residents reviewed with feeding tubes. Specifically, for Residents #61 and #62, feeding formula was not labeled properly with resident's name, date and time hung, rate of feeding, or the nurse's initials; and for Residents #61 and #50 infection control practice was compromised by observations of a dirty feeding tube syringe and an enteral feeding tube clog remover uncovered at the bedside. The findings include: Policy titled Enteral Feeding revised 02/24/2016 documented formula container should be labeled with resident name, room number, date, starting time, rate at milliliters per hour, and nurse initials. 1) Resident #61 diagnoses including cerebral infarction (stroke), congestive heart failure, and dysphagia (difficulty swallowing). The quarterly Minimum Data Set assessment dated [DATE] documented Resident #61 was moderately cognitively intact and was dependent on staff for nutrition/feeding tube. The physician order dated 05/13/2026 documented Jevity 1.5 (type of feeding) full strength via gastrostomy tube 70 milliliters continuous. Start at 5 PM for a total of 1680 milliliters total volume. The physician order dated 05/13/2026 documented water flush of 60 milliliters per hour continuous every shift for a total of 1940 milliliters total volume flush for 24 hours. Medication flush of 30 milliliters before and 30 milliliters after medications given. The care plan for tube feeding, dated 07/16/2025, documented the goal of optimal nutrition/hydration status secondary to diagnosis with tube feeding tolerance. During an observation on 07/22/2026 at 8:50 AM Resident #61 did not have their formula bottle labeled with resident name, date, time, rate or nurse initials. There was an enteral feeding tube clog remover lying on the bedside table uncovered, not in a bag. During an interview on 07/22/2026 at 8:50 AM, Licensed Practical Nurse #57 stated Resident #61's tube feeding formula bottle should have been labeled. They did not hang the formula; it was already running when they started their shift at 7AM. They stated the enteral feeding tube clog remover was usually stored in the packaging it came in. The staff could use it for 24 hours before replacing it. They were not sure how long the one at bedside had been left open to air. 2) Resident #62 diagnoses included injuries of the head, dysphagia, and diabetes mellitus. The quarterly Minimum Data Set assessment dated [DATE] documented Resident #62 had severely compromised cognition and was dependent on staff for all cares and feeding. The physician order dated 03/13/2026 documented Nutren 2.0 (type of feeding) via pump at 60 milliliters per hour. Start at 9 PM, stop at 9 AM for a total of 720 milliliters total volume. The physician order dated 03/13/2026 documented water flush of 250 milliliters at 6AM, 11 AM, 3 PM and 7 PM for a total volume of 1000 milliliters water flush, and flush of 30 milliliters before and 30 milliliters after medications given. The care plan for tube feeding, dated 09/20/2021, documented a potential for decline from refusing tube feeds, cares and pulling the feeding tube out. An intervention to adjust tube feeding as indicated by clinical symptoms. During an observation on 07/22/2026 at 9:05 AM Resident #62 did not have their formula bottle labeled with resident name, date, time, rate or nurse initials. During an interview on 07/22/2026 at 9:05 AM, Licensed Practical Nurse #5 stated Resident #62 tube feeding formula bottle should have been dated when it was hung last night. Licensed Practical Nurse #5 stated if a tube fed resident required the use of an enteral feeding tube clog remover it should be dated, stored in the package it came in and thrown out after 24 hours. During an interview on 07/22/2026 at 12:47 PM, the Assistant Director of (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335845	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Northeast Ctr for Rehabilitation and Brain Injury		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Grant Avenue Lake Katrine, NY 12449	
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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nursing stated all tube feeding formula and the water flush bags should be labeled with the resident name, date, time hung, the rate and the room number. They were not sure why staff was not documenting the required information on the feeding formula when hung. 3) Resident #50 had diagnoses including anoxic brain damage and dysphagia. The Minimum Data Set, dated [DATE] documented Resident #50's cognition was severely impaired. They were dependent on staff for all care and they had a feeding tube. During an observation on 07/21/2026 at 11:15 AM Resident #50's top drawer contained a dirty feeding tube syringe in a plastic bag with what appeared to be remanent medication or mold. There was no date on the bag. During the observation, Registered Nurse #92 was interviewed and stated the feeding tube syringe should not have been stored in the top drawer. They were not sure why it was there and did not know how long it had been in the drawer. They typically hang them from the feeding pole and are stored in the original packing bag. The night shift staff distribute new syringes daily. During an interview on 07/22/2026 at 12:47 PM the Assistant Director of Nursing stated tube feeding syringes could be used for 24 hours and should be stored in their bag hanging on the feeding pole or on the bedside table. They also stated enteral feeding tube clog removers were not multi use and a new one should be used each time for infection control purpose. They were not sure why staff would reuse the enteral feeding tube clog removers. 10 New York Codes, Rules and Regulations 415.12(g)(2)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335845	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Northeast Ctr for Rehabilitation and Brain Injury		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Grant Avenue Lake Katrine, NY 12449	
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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation and interviews conducted during the survey, the facility did not ensure residents were provided with food and drink that was palatable, and at a safe and appetizing temperature. Specifically, the lunch meal on 07/21/2026 was not at a palatable appetizing temperature. The findings include: The facility policy titled Trays and Trayline Standards documented, standards are in place to promote excellence in meal service and compliance within state and federal guidelines for time, temperature, and sanitation During a phone interview on 06/11/26 at 11:11 AM, Resident #39 stated they could not eat the food at the facility and ate out of a jar of peanut butter. During a phone interview on 07/16/2026 at 12:21 PM, Resident #44's representative stated the food was always cold. During an interview on 07/20/2026 at 10:57 AM, Resident #63 stated breakfast was the coldest meal that they were served. The eggs were cold, and the toast was sometimes warm. During an observation of lunch meal service on the Rehab unit on 07/21/2026, food cart #1 arrived on the unit at 11:56 AM, the first meal tray was passed at 11:58 AM and the last meal tray was passed from cart #1 at 12:17 PM. Food cart #2 arrived on the unit at 12:04 PM, the first meal tray was passed at 12:14 PM and the last meal tray passed was 12:24 PM. Both food cart doors were left open during the passing of trays. The last meal tray was the test tray for the following temperatures: Cheeseburger 106 degrees Fahrenheit, cheese was not melted, lukewarm Vegetable blend 104 degrees Fahrenheit, cold to taste French Fries 100 degrees Fahrenheit, cold with tough texture Coffee 125 degrees Fahrenheit, warm but acceptable Cream of [NAME] 116 degrees Fahrenheit, warm but acceptable Milk 60 degrees Fahrenheit, not cold to taste, unappetizing Juice 66 degrees Fahrenheit, not cold to taste During an observation on 07/21/2026 at 12:40 PM, of the tray line in the kitchen, the milk cooler door was left open while building the meal trays. During a review of the food temperatures log recorded at 11 AM, from the steam table prior to food plating and loading into the food carts, documented the cheeseburger was 172 degrees Fahrenheit, the vegetable blend was 174 degrees Fahrenheit, and there was no temperature documented for the french fries, cream of rice, milk and juice. During an interview on 07/21/2026 at 12:40PM, the Food Service Director stated they used the plate warmer and the pellet system, but did not have insulated food carts. They stated they did not obtain temperatures of the cold food items before meal service, only the hot foods. A carton of milk from the cooler on the tray line was tested for temperature and was 46 degrees Fahrenheit. The Food Service Director stated the milk cooler temperature was running high last month and it had since been repaired. They also stated leaving the door open to the cooler during the tray line was a typical procedure. The Food Service Director stated maybe they needed new equipment for the milk and insulated meal carts for delivery. During an interview on 07/22/2026 at 1:24 PM, the Assistant Administrator stated the kitchen equipment may be old and need some repairs or to be replaced. 10 New York Codes, Rules, and Regulations 415.14 (d)(1)(2).		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335845	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Northeast Ctr for Rehabilitation and Brain Injury		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Grant Avenue Lake Katrine, NY 12449	
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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews during the abbreviated survey, the facility did not ensure the inclusion of the family/resident representative in the development of the plan of care for two (2) of eight (8) residents reviewed for resident rights. Specifically, 1) Resident #8 was on one-to-one supervision for safety for behaviors and fall history. The facility removed the one-to-one supervision on 11/13/2025 without discussion with, or notification of, the family, and 2) Resident #6's representative was not included in the care planning process and did not hold an initial team care plan meeting until six (6) weeks after Resident #6's admission to the facility. The findings include: 1. Resident #8 had diagnoses that included dementia, aphasia, and abnormalities of gait and mobility. The Minimum Data Set assessment dated [DATE] documented severely impaired cognition, no mobility devices used, maximum assistance with activities of daily living, touch assist for transfers, moderate assistance for ambulation of 50 feet or more, and family participation in assessment and goal setting. The physician order dated 03/17/2025 documented one to one supervision every shift and every day. The nursing, physician, social work, and progress notes dated 10/31/2025 to 11/13/2025 had no documented evidence that the family was notified of a change in their plan of care or discontinuation of the one to one supervision on the 7 AM to 3 PM shift. The physician order dated 11/13/2025 documented one to one supervision every day on the 3 PM to 11 PM and 11 PM to 7 AM shifts. The care plan conference note dated 11/20/2025 documented a meeting, son attended by phone, and resident continues to require one-to-one at all times for pica behavior. During an observation and interview on 06/02/2026 at 10:55AM, Resident #8 was observed lying in bed without supervision. Certified Nurse Aide #18 stated that Resident #8 was no longer on one-to-one supervision. During an interview on 06/03/2026 at 12:17 PM, the resident's representative stated that they were not as concerned about the 1:1 supervision for Resident #8 anymore because of their physical decline and decreased mobility. However, when Resident #8 did need supervision, the facility would discontinue the supervision without informing or consulting with the family. During an interview on 06/04/2026 at 10:07AM, Registered Nurse Unit Manager #31 stated that Resident #8 was admitted to the facility with a history of falls and sustained multiple falls after admission to the facility. The family requested increased supervision and one-to-one supervision was (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335845	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Northeast Ctr for Rehabilitation and Brain Injury		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Grant Avenue Lake Katrine, NY 12449	
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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	implemented. They stated that as Resident #8 declined they would try to decrease the supervision. They did recall the family being informed of changes to the one-to-one supervision but unable to provide specific dates. The family often voiced disagreement with the proposed changes to the supervision. They stated the communication should have been documented in the electronic medical record. During an interview on 06/04/2026 at 10:30AM, Social Worker #22 stated that they did recall the family expressing concerns about changes to the one-to-one supervision for Resident #8. When the family had concerns, they would communicate those to the Unit Manager or the Director of Nursing. Nursing determined who received the supervision, if any changes to the supervision were being made, and communicating any changes to the family. They stated there was a care plan meeting on 11/18/2025, but no documented discussion related to the one-to-one supervision or changes to the supervision. During an interview on 06/04/2026 at 10:47AM, the Director of Nursing stated that they re-evaluated the one-to-one supervision for all residents every quarter and might adjust the timing or frequency of the supervision. They would inform the family of any changes. They stated that they had communicated with Resident #8's family regarding changes to their supervision on occasion but were unable to provide specific dates. Any communication would be documented in the electronic medical record. 2. The facility policy titled Baseline Care Plan Summary revised 02/2024 documented the facility must provide the resident and their representative with a written summary of the baseline care plan and to ensure the resident representative is informed of the initial plan of care and services to be provided. The baseline care plan summary must include any treatment /services to be provided by the facility, it must be completed with the resident or representative and if it is completed verbally, it must be documented on the summary and mailed. The facility policy titled Comprehensive Care Plan revised 02/2024 documented comprehensive care plan is developed for each resident neighbor to provide a mechanism for the resident neighbor and family input to their care plan. Resident neighbor and their representative are invited to attend the initial, significant change and annual care plan meetings set up by social work. Resident #6 had diagnoses that included Chronic respiratory failure and trach dependent, anoxic brain damage, dysphagia with feeding tube, and persistent vegetative state. The Minimum Data Set assessment dated [DATE], documented Resident #6 was in a persistent vegetative state and was dependent for all cares. A progress note dated 12/16/2025 at 11:56 AM documented the nurse spoke with Resident #6's representative to discuss the baseline care plan, that the representative expressed understanding, and that there would be an initial care plan meeting in the next couple of weeks when they can ask the team about the plan of care in its entirety. The baseline care plan included physician ordered medications, diagnosis, and dietary orders. (continued on next page)		

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335845	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Northeast Ctr for Rehabilitation and Brain Injury		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Grant Avenue Lake Katrine, NY 12449	
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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/02/2026 at 1:38 PM the Director of Social Work stated Resident #6's first team care plan meeting was 01/29/2026. The former Director had contacted the family to set up the meeting. The Director of Social Work stated they thought the facility policy was to have a care plan meeting within 14 days of admission. The meeting was held six (6) weeks after admission. Social Worker #20 that attended the meeting stated the previous Director of Social work had resigned and the department was short staffed. This was the first available meeting time for Resident #6's team care plan meeting. The original meeting time offered to Resident # 6's representative was 01/21/2026 but they had requested it be held 01/29/2026 so that both of Resident #6's representatives could attend the meeting by phone. Staff attendance to the meeting was occupational therapy, respiratory therapy, registered dietitian and social worker. Physical therapy had been discontinued by the time the meeting was held. During an interview on 06/09/2026 at 10:55 AM Resident #6's representative stated they had to wait six (6) weeks to have a team care plan meeting. The representative questioned the delay in the meeting time and was told by social work this was the first available time, and they had no control over that. During an interview on 06/09/2026 at 2:25 PM the facility Administrator stated the initial team care plan meeting with family should take place within the first one (1) to two (2) weeks of admission to the facility. 10NYCRR 415.11(c)(2)(i-iii)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335845	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Northeast Ctr for Rehabilitation and Brain Injury		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Grant Avenue Lake Katrine, NY 12449	
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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on record review and interview during survey, the facility failed to ensure the resident's/ resident representative's right to make choices about aspects of life that were important to the resident for one of two residents reviewed for discharge planning. Specifically, Resident #19's representative requested referrals be sent to other facilities for the resident to transfer to. The resident representative made the request in June 2025 and there was no documented evidence of any referrals started until 09/09/2025. Findings include: Resident #19 had diagnoses including anoxic brain damage (caused by lack of oxygen), cardiovascular accident (stroke) and quadriplegia. The admission Minimum Data Set (assessment tool) dated 06/12/2025, documented Resident #19's cognition was moderately impaired. Resident #19 required substantial to maximal assistance for upper body dressing and was dependent on staff for lower body dressing. The 06/04/2025 discharge planning note documented the resident wished to return home with their family and there were three to four stairs to enter the house. The 06/10/2025 care conference summary documented Resident #19's family member had applied for Social Security and the Traumatic Brain Injury Waiver program for the resident. The 6/10/2025 discharge planning note documented the resident wished to return home with their family. A grievance form dated 06/17/2025, completed by Social Worker #16 documented they had called to speak to Resident #19's family member about a referral packet being sent. This was not documented in the resident's electronic medical record. The 07/15/2025 discharge planning note documented the resident wanted to return home and the family member applied for Social Security and the Traumatic Brain Injury Waiver. The 09/09/2025 Discharge Planning progress note documented Social Worker #16 emailed packet of information and referral to a program that helps transition from nursing home to community. During a phone interview on 06/04/2026 at 11:14 AM, the resident's family member stated they wanted Resident #19 transferred to a different facility. They discussed it shortly after Resident #19's admission and it took the social worker four months to do anything. The family member stated they gave Social Worker #16 a list of facilities to apply to and when they called the facilities, the facilities reported not receiving any information. During an interview on 06/04/2026 at 12:38 PM, Social Worker #16 stated when a resident's family member requested to transfer the resident to another facility they would send the referral to the other facility. They stated families gave them information on places they wanted to transfer, and they would call the facility, get their fax number and fax the necessary paperwork. They stated sometimes there was no availability, and some facilities did not call back. The Social Worker stated they usually send the referral and give a couple days to hear back and then call the Admissions Department. They stated they kept track of who they sent referrals to and then followed up with the family and put a note in the electronic medical record under discharge planning. They stated Resident #19 went home under the Traumatic Brain Injury Waiver program. They stated they sent the referral package to a program that helps transition from nursing home to community on 09/09/2025 and other facilities after that. They stated that was when they started the referral process. Social Worker #16 was given the grievance form dated 06/17/2025 and stated they had called the family member that day and they started the referral process and sent referrals to some facilities in June 2025. They reviewed the electronic medical record and stated they could not find documented evidence of any referrals sent prior to 09/09/2025. 10 New York Codes, Rules and Regulations 415.5(b)1-3		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335845	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Northeast Ctr for Rehabilitation and Brain Injury		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Grant Avenue Lake Katrine, NY 12449	
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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews during the abbreviated survey, the facility did not ensure that a resident's representative was promptly notified of a change in status for one (1) of five (5) residents (Resident #6) reviewed for skin breakdown. Specifically, Resident #6's designated representative was not made aware the resident had been readmitted from a hospitalization on 03/27/2026 with moisture associated skin damage. Subsequently, on 04/08/2026 the wound was documented as unstageable. The designated representative was not aware of skin breakdown until Resident #6 was sent to the hospital on [DATE]. The findings are: The policy for responsible party/provider notification reviewed 06/2025 documented notification of responsible parties of pertinent clinical or other relevant information regarding the neighbor; when there is a change in physical status and care and services needs have changed. Resident #6 had diagnoses that included chronic respiratory failure and trach dependent, anoxic (lack of oxygen) brain damage, dysphagia (difficulty swallowing) with feeding tube, and persistent vegetative state. The admission Minimum Data Set assessment dated [DATE], documented Resident #6 was in a persistent vegetative state and was dependent for all cares. The Nursing Progress Note dated 04/03/2026 documented an area of concern noted to the sacral area upon return to facility after recent hospital admission. Area noted with Moisture Associated Skin Damage, wound Nurse Practitioner made aware, will see for wound rounds. The Physician Order dated 04/03/2026 documented sacral area with Moisture Associated Skin Damage, cleanse with soap and water, pat to dry, Triad cream every day. The Nursing Progress Note dated 04/08/2026 documented Resident #6 seen for wound rounds with Nurse Practitioner; see wound care progress note. Treatment completed by wound team, orders and care plan updated. Area to sacrum changed to unstageable. The Physician Order dated 04/09/2026 documented unstageable necrotic wound sacrum, wound cleanser, pat to dry, PluroGel plus Calcium Alginate, Opti foam every day. During an interview on 06/04/2026 at 9:51 AM Resident #6's family member stated Resident #6 was admitted to the hospital on [DATE] from the facility and the receiving hospital told them that Resident #6 had wounds to both buttocks. During an interview on 06/09/2026 at 11:20 AM, Unit Manager Registered Nurse #41 stated upon return from a hospitalization the unit manager would typically call family to update them on what transpired during the hospitalization including wounds and medication changes. This would be documented in the medical record. Unit Manager Registered Nurse #41 stated Resident #6 did not have any wounds prior to the hospitalization on 03/27/2026 but was readmitted with Moisture Associated Skin Damage to the coccyx and was seen by the Wound care team on 04/08/2026. They stated there was no note in the medical record to indicate the family was notified of the new skin breakdown. 10 New York Code Rules Regulations 415.3(f)(2)(ii)(b)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335845	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Northeast Ctr for Rehabilitation and Brain Injury		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Grant Avenue Lake Katrine, NY 12449	
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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on record review and interviews, the facility did not ensure each resident was free from verbal and mental abuse for one of five residents (Resident #13) reviewed for abuse. Specifically, on 10/19/2025 Resident #13 reported that Certified Nurse Aide #19 stated to them that they did not like them and used vulgar language to describe their bowel incontinence. The findings include: The Policy for abuse prevention policy last reviewed 11/2024, documented that this facility is to promote an environment that supports each resident's right to be free from abuse, neglect, mistreatment, misappropriation of resident property, and exploitation. Abuse includes verbal abuse, sexual abuse, physical abuse, and mental abuse. Resident #13 had diagnoses that included traumatic subdural hemorrhage to the brain, hepatic encephalopathy, and hemiplegia affecting the dominant right side. The quarterly Minimum Data Set (a resident assessment tool) dated 9/30/2025 documented Resident #13 had intact cognition and was dependent for toileting hygiene and toileting transfers. Resident #13 was frequently incontinent of bladder and always incontinent of bowel. The Care Plan for potential victim of abuse dated 9/23/2025 documented that the resident was vulnerable due to physical and cognitive disabilities. The Care Plan for elimination dated 9/23/2025 documented that the resident was frequently incontinent. Check and change the resident every two to three hours and as needed. The Accident and Incident Report dated 10/19/2025 documented that Resident #13 reported that Certified Nurse Aide #19 stated to them that they did not like them and used vulgar language to describe their bowel incontinence. Certified Nurse Aide #19 was removed from the area and suspended. The facility investigation concluded that there was sufficient cause to believe that abuse had occurred and Certified Nurse Aide #19 was terminated. During an interview on 6/02/2026 at 2:10 PM, Resident #13 stated Certified Nurse Aide #19 took their time giving care and made a comment that they hated Resident #13 and that Resident #13 was always causing problems. They stated Certified Nurse Aide #19 always treated them badly and always had an attitude. They stated Certified Nurse Aide #19's comments made them feel insignificant and depressed. During an interview on 06/04/2026 at 12:03 PM, Certified Nurse Aide #30 stated they were assigned to Resident #13 when Certified Nurse Aide #19 upset the resident. They stated Resident #13 told them that they were covered in feces due to medications and needed to be cleaned. They stated Certified Nurse Aide #19 told Resident #13 that they did not like them and used vulgar language describing their bowel incontinence. Resident #13 was upset and crying. Certified Nurse Aide #30 stated they informed Licensed Practical Nurse #60. During a telephone interview on 06/10/2026 at 11:17 AM, Licensed Practical Nurse #60 stated they were told by Certified Nurse Aide #30 what Resident #13 had reported. Licensed Practical Nurse #60 asked Resident #13 what was stated to them and by which staff member. Resident #13 told them what was said to them and that Certified Nurse Aide #19 was the staff member. During an interview on 06/11/2026 at 10:34 AM, the Director of Nursing stated Resident #13 was alert and orientated, and their story never changed on what Certified Nurse Aide #19 had stated to them. They stated Resident #13 was consistent with their story and had not had any fabrication or issues with other staff members. 10 New York Code Rules Regulations 415.4(b)(1)(i)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335845	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Northeast Ctr for Rehabilitation and Brain Injury		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Grant Avenue Lake Katrine, NY 12449	
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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews conducted during the abbreviated survey, the facility did not ensure baseline care plans were developed and communicated for resident two (2) (Residents #6 and #37) of 11 residents reviewed for resident rights. Specifically, there was no documentation that the baseline care plan was given to the Resident and/or a Resident Representative. The findings include: The facility policy titled Baseline Care Plan Summary revised 2/2024 documented the facility must provide the neighbor and their representative with a written summary of the baseline care plan. The baseline care plan summary is completed with the neighbor or representative and must be signed by whomever it is complete/reviewed with and printed with a written copy provided to the resident or resident representative. If the summary is completed verbally this must be documented on the summary and mailed. 1) Resident #6 was admitted to the facility on [DATE] with diagnoses of chronic respiratory failure, anoxic brain damage, and persistent vegetative state. The Minimum Data Set assessment dated [DATE] documented Resident #6 was in a persistent vegetative state and dependent for all cares. There was documentation of a Baseline Care Plan developed on 12/16/2025 with documented physician medication orders, diagnosis, dietary orders and was signed by the Nurse Manager. There was documentation of a checked mark in the box titled Responsible Party. A nursing progress note dated 12/16/2025 documented the nurse spoke with Resident #6's representative over the phone and discussed the 48-hour care plan and the representative expressed understanding. The nurse documented the discussion of a care plan meeting within the next couple of weeks. During an interview on 06/02/2026 at 1:23 PM, the Director of Nursing stated the baseline care plan box for responsible party was checked meaning the responsible party was informed. There was no check mark on the box for Mailed and there was no free text documenting any discussion with the responsible party, nor a signature of the responsible party. During an interview on 06/04/2026 at 9:51 AM, Resident # 6's responsible party, stated they did not receive a copy of the baseline care plan. During an interview on 06/09/26 at 11:38 AM former Unit Manager Registered Nurse #43 stated it was not a policy of the facility to mail baseline care plans. During an interview on 06/09/2025 at 12:00 PM the Director of Social Work stated if a resident or representative ask for a copy of the care plan, they will give it and to their knowledge the daughter did not get a copy of the baseline care plan summary. During an interview on 06/09/2026 at 2:25 PM the facility Administrator stated the baseline care plan should be given to the family. 2) Resident #37 was admitted to the facility on [DATE] with diagnoses of cholelithiasis, kidney cancer, and diabetes mellitus. The Minimum Data Set assessment dated [DATE] documented Resident #37 had intact cognition and required maximum assistance for sit to lying, sit to standing, toilet transfers, and transfers. There was documentation of a Baseline Care Plan developed on 04/14/2025 with documented physician medication orders, diagnosis, diet order and to follow up with urology and routine consults. It was signed by the Registered Nurse supervisor. There was no documentation that the baseline care plan was provided to anyone. A nursing progress note documented the baseline care plan was written out and was to be discussed with the responsible party. There was no documentation that the summary was given to the resident or the responsible party. During an interview on 6/17/2026 at 2:24 PM the Assistant Director of Nursing stated the documentation indicated the baseline care plan was not given to anyone. No checked boxes to indicate the resident, responsibly party, or legal guardian had been given the baseline care plan summary or that it had been mailed. 10 New York Codes, Rules, and Regulations 415.11		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335845	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Northeast Ctr for Rehabilitation and Brain Injury		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Grant Avenue Lake Katrine, NY 12449	
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 - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not ensure residents were provided treatment and care in accordance with professional standards of practice for one of three residents (Resident #18) reviewed for respiratory care. Specifically, when Resident #18 was unresponsive, in respiratory distress and had elevated blood pressure, there was no documented times as to when the physician was called, when symptoms started and the orders given. When nitroglycerin was given for elevated blood pressure, the order was not documented, the time given and vital signs before and after administration were not documented. Additionally, there was no documentation of the involvement of the Medical Director or their conversation with the family member. Resident #18 was admitted to the facility on [DATE] with diagnoses including respiratory failure, anxiety disorder, and was ventilator dependent. The facility policy and procedure for Change in Condition, initiated 06/10/13 and last reviewed 10/2024, documented the purpose was to ensure the accurate and timely provision of health care services. The procedure included notifying medical staff regarding significant changes in resident's condition, and the nurse shall document the date, time, and name of each physician notified, orders given, actions taken and/or response to actions taken. The facility policy and procedure for Emergency Transfer of Resident Neighbor, dated 06/10/2013 and last reviewed 06/2024, documented the decision to transfer a resident to an acute care hospital was made by a physician or the nursing supervisor (in the absence of a physician). License Practical Nurse #40's nursing progress note dated 01/13/2026 at 10:58 AM, documented the resident's blood pressure 122/74, pulse 80, and temperature 98 degrees Fahrenheit. The resident was resting in bed, alert and could make needs known; tolerating tube feeding and water, sleeping with call bell in reach. Registered Respiratory Therapist #42's progress note on 01/13/2026 at 11:44 AM, documented they met with Resident #18 and their family member and answered questions about the ventilator and the resident's breathing. They discussed the ventilator weaning protocol and about working with physical therapy to build strength and they would begin the weaning process when the resident was able. The resident and family member understood and thanked them. License Practical Nurse #40's progress note dated 01/13/2026 at 2:30 PM, documented blood pressure 170/112, pulse 124, resident having respiratory distress, nonresponsive, agonal breathing (severe gasping for air), family at bedside, physician called, blood sugar 124, per physician nitroglycerin patch put on with no effect, family crying at bedside demanding an ambulance be called, physician ordered to send resident to emergency room. Registered Nurse #43's progress note dated 01/13/2026 at 2:39 PM, documented the resident continued to be nonresponsive. Physician ordered to send to emergency room. Blood pressure had not shown any improvement. Medical Director was made aware and okayed sending resident out. 911 was called and family member remained at bedside. Registered Respiratory Therapist #42's progress note on 01/13/2026 at 3:43 PM, documented they were asked to assess the resident who was agonal breathing in the 40's (respirations per minute) and was unable to be aroused. They removed the resident from the ventilator and bagged (used a portable, hand-held device to provide positive pressure ventilation) on 100% oxygen without difficulty; bilateral breath sounds diminished at bases. Suctioned with minimal white thin secretions. They were placed back on the vent, settings adjusted, heart rate 109 and still unable to arouse. Resident #18's family member was at the bedside and stated they had never seen the resident like that and was concerned they might be having a stroke. The nursing supervisor, physician and Medical Director were notified that the family member was requesting the resident to be sent to the emergency room. Sent out for further (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335845	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Northeast Ctr for Rehabilitation and Brain Injury		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Grant Avenue Lake Katrine, NY 12449	
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 - Minimal harm or potential for actual harm Residents Affected - Few	evaluation. Resident #18's face sheet documented they were discharged on 01/13/2026 at 3:08 PM. During a telephone interview on 06/04/2026 at 12:00 PM, the resident's family member stated the resident was found unresponsive around 1:30 PM on 01/13/2026 and had to wait a long time to send to the hospital. They were questioned extensively as to if they really wanted to send Resident #18 to the hospital with their Do Not Resuscitate status. They stated the resident was not sent out until after 3:00 PM. During an interview on 06/09/2026 at 11:50 AM, Licensed Practical Nurse #40 stated they did not remember much about the resident. Licensed Practical Nurse #40 reviewed the resident's record and their note dated 01/13/2026 at 2:30 PM and stated they remembered the resident had agonal breathing and it took a while for the ambulance to come and the family member at the bedside was anxious. They stated they took vital signs, called the physician and the physician ordered nitroglycerin patch and said to give it half an hour to work. They stated they did not remember if they talked to the physician or if the supervisor did and they were unsure what time the nitroglycerin patch was applied. Licensed Practical Nurse #40 continued to review the residents record and stated there were no documented vital signs after the nitroglycerin patch was applied. Registered Nurse #41 was present during the interview and stated they could not find documented vital signs after the nitroglycerin was applied or an order for the nitroglycerin. During an interview on 6/9/2026 at 1:55 PM, Respiratory Therapist #42 stated on 01/13/2026 they saw the resident earlier in the day and discussed the ventilator weaning process with the resident and their family member. They stated Resident #18 was alert, oriented and talking when they saw them at that time. Later they were called, and the resident was unresponsive. They bagged the resident to see if they had a plug and they were able to bag easily, the oxygen saturation was good, but the resident was unresponsive. They stated the family member was in the room and very worried saying this was abnormal for the resident. They stated they spoke to the family member and told them they could request the resident be sent out. They stated they would have liked to have seen the resident sent out earlier but there was a process. The process was for the Nursing Supervisor or Unit Manager to assess the resident and then call the physician. The physician needed to get permission from the Medical Director before the resident could be sent out. They stated the family member actually got the ball rolling by requesting they send the resident out. During an interview on 06/12/2026 at 7:55 AM, Physician #1 reviewed Resident #18's record and stated they saw the resident on date of admission, 01/12/2026. On 01/13/2026, they were called and told the resident's heart rate was elevated, they were having agonal breathing, and the blood pressure was elevated. They said they ordered nitroglycerin paste for the elevated blood pressure and it was ineffective as results should have been immediate. They stated they were not onsite and the resident was sent out immediately after the nitroglycerin was given but they were sent out for respiratory distress. They stated they thought the blood pressure in Licensed Practical Nurse #40's progress note was after the nitroglycerin was given and they would expect the blood pressure to be documented before and after the nitroglycerin. They stated the team would have responded to the resident immediately as the ventilator would alarm when the resident was in distress and respiratory and nursing would respond. They would do assessments, and try adjusting ventilator settings to see if they could reverse the condition. They would call the physician for instructions and then be sent to the hospital if needed. Physician #1 stated Licensed Practical Nurse #40's progress note documented the time as 2:30 PM and they did not know the time span from the beginning of symptoms to calling 911 and thought it was timely. They stated permission was needed from the Medical Director prior to sending a resident out. They stated they did not call the Medical Director, they gave the nurse the order to call 911 and call the Medical Director at the same time. During a telephone interview on 06/16/2026 at 10:26 AM, Registered Nurse #43 stated they were a per diem (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335845	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Northeast Ctr for Rehabilitation and Brain Injury		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Grant Avenue Lake Katrine, NY 12449	
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 - Minimal harm or potential for actual harm Residents Affected - Few	Nursing Supervisor and initially could not recall Resident #18. They reviewed the notes in the resident's record including their progress note, Licensed Practical Nurse #40's note and Respiratory Therapist #42's note. They stated they were called to the resident's room after the nitroglycerin paste was applied. They stated someone else got the order for the nitroglycerin paste and it should have been documented and was not; they were unsure when it was applied or when the resident started having respiratory distress. They stated they sent a text message to Physician #1 on 01/13/2026 at 1:41 PM to give an update on the resident's condition after collaborating with Respiratory Therapist #42. They stated they had a text message at 2:19 PM to send the resident to the hospital. Registered Nurse #43 stated they were upset at the time because they had to get permission from the Medical Director to send the resident out. The resident's family member was very upset and wanted the resident to go to the hospital. They stated the Medical Director did not want the resident sent out and had a phone conversation with the resident's family member regarding advanced directives, which upset them more. They stated Physician #1 said to send the resident to the hospital and the Medical Director finally gave permission. 10 New York Codes, Rules and Regulations 415.12		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335845	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Northeast Ctr for Rehabilitation and Brain Injury		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Grant Avenue Lake Katrine, NY 12449	
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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews during the abbreviated survey, the facility did not ensure that residents received care consistent with professional standards to prevent pressure ulcers for two of eight residents (Resident #8 and #19) reviewed for pressure ulcers. Specifically, 1) Resident #8 developed a pressure ulcer while in the facility, turning and positioning was inconsistently signed for, and Resident #8 was observed without pressure relieving devices in place as indicated on the care plan during the onsite visit from 06/02/2026 to 06/04/2026. 2) Resident #19 developed pressure ulcers and care plan interventions were not implemented timely including an air mattress that was added to the care plan on 06/01/2025 and not put in place until 06/20/2025; during that time the pressure ulcer worsened. The findings include: The facility Skin/Pressure Injury Prevention & Intervention Program policy last revised 4/2024 documented the purpose is to prevent pressure injuries and provide multidisciplinary interventions for those residents with pressure injuries. Residents at risk for skin/pressure injuries will have a preventive plan implemented. Residents with skin/pressure injuries will have an intervention plan in addition to prevention plan which includes all applicable disciplines. The progress of the comprehensive care plan will be evaluated on an ongoing basis and revised as needed. 1)Resident #8 had diagnoses that included dementia, impaired gait and mobility, and falls. The Registered Nurse Skin Assessments from 11/2025 documented no areas of concern. The wound care note dated 12/19/25 documented seen for quarterly assessment, pressure relieving measures encouraged for sacrum, hips, heels, and malleolus; right lateral malleolus small reddened area. The wound care note dated 12/31/2025 documented possible compromised skin to heels and ankles. Continue pressure relieving interventions. The Certified Nurse Aide care log from 12/2025 documented turning and positioning as completed on 35 of 93 shifts with omissions or documentation that it was not completed on the remaining 58 shifts. The wound care note dated 1/07/2026 documented sacral wound and right malleolus assessment. Facility staff reported the resident had a new wound to the sacral area. The right malleolus was previously identified as an area of concern without an open area, an open area now present. Right malleolus unstageable pressure ulcer measured 1.2 centimeters by 2.0 centimeters by 0.1 centimeters and the sacrum unstageable pressure ulcer measured 2.5centimeters by 3.0 centimeters by 0.1centimeters. The wound care note dated 01/14/2026 documented sacral wound and right malleolus wound assessments. Third wound to left heel, deep tissue injury, also assessed. Right malleolus unstageable (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335845	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Northeast Ctr for Rehabilitation and Brain Injury		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Grant Avenue Lake Katrine, NY 12449	
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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pressure ulcer 1.2 centimeters by 2.0 centimeters by 0 centimeters; sacrum unstageable pressure ulcer 2.5 centimeters by 3 centimeters by 0.3 centimeters; left heel deep tissue injury 3.0 centimeters by 4.5centimeters by 0 centimeters. The Significant Change Minimum Data Set assessment dated [DATE] documented severely impaired cognition dependent on staff assistance for toileting and personal hygiene, non-ambulatory, always incontinent of bowel and bladder, and three (3) unstageable pressure ulcers not present on admission. The At Risk for Impaired Skin Integrity Care Plan last revised 04/23/2026 documented interventions including keep skin clean and dry, pillow between legs when in bed, air mattress, and alert wound care team if changes noted. The wound care note dated 05/27/2026 documented unstageable right malleolus 1.5centimeters by 0.6 centimeters by 0 centimeters; sacrum 0.8 centimeters by 0.8 centimeters by 1.8 centimeters by; and left heel stage 3; 1centimeters by 1.5centimeters by 0 centimeters. The Impaired Skin lcentimeters byntegrity Care Plan last revised 06/01/2026 documented interventions including turn and reposition per schedule every 2-4 hours, pressure relief mattress, offload heels with pillows when in bed, and bilateral heel boots when out of bed. During an observation on 06/02/2026 at 10:55AM, Resident #8 was observed lying in bed with an air mattress in place and heels directly on the mattress. During an observation on 06/02/2026 at 11:42AM, Resident #8 was observed sitting up in reclining wheelchair in the common area on the unit, leg rests in place, legs partially on leg rests with no heel boots or other protective device for heels in use. During an observation on 06/03/2026 at 9:20AM, Resident #8 was observed in bed on right side, resting with their eyes closed, air mattress in place, heels directly on mattress, no pillow between legs. During an interview and observation on 06/04/2026 at 09:57 AM, Resident #8 was observed lying in bed with heels directly on mattress with no pillow between their legs. Licensed Practical Nurse #17 stated no pillows or heel boots were used because the resident had an air mattress. Wound dressing intact and changed that day, Licensed Practical Nurse #17 pulled dressing back for observation. Wound appeared small, circular, mild redness around opening, no odor and packing observed coming from wound. Resident tolerated well. The current Certified Nurse Aide Care Card documented apply pillow between legs when in bed, offload heels with pillows when in bed, and bilateral heel boots when out of bed. During an interview on 06/04/2026 10:07AM Registered Nurse Unit Manager #31 stated that Resident #8 had pressure ulcers that developed at the facility but have improved. They expect pressure ulcer prevention to be followed as care planned. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335845	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Northeast Ctr for Rehabilitation and Brain Injury		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Grant Avenue Lake Katrine, NY 12449	
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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/9/2026 at 9:31AM Certified Nurse Aide #18 stated that Resident #8 was dependent for all cares, incontinent, and had wounds. They stated they had an air mattress in place. As per the care card, they should have had a pillow to offload their heels in bed and between the legs in bed. Turning and positioning should be every two to four hours. The care card also documented heel boots when out of bed which should have been used but they thought those were discontinued. They stated certified nurse aides needed to sign for the interventions to show they were done. During an interview on 6/9/2026 at 11:55AM, Wound Care Registered Nurse stated that Resident #8 did develop wounds at the facility. They were improving. Multiple interventions were in place including an air mattress, heel boots when out of bed, pillow to offload heels in bed, and turn and position every 2 hours. They stated that that the interventions on the care plan should be followed and documented. During an interview on 06/10/2026 at 11:00AM, the Wound Care Nurse Practitioner stated that they saw Resident #8 for their wounds on their sacrum, heel and malleolus (ankle). They stated that the wounds developed in January 2026 at the facility. The wounds were caused by pressure, and they recommended pressure relieving interventions at their first assessment. They referred to rehabilitation and the facility nursing staff to decide on the most appropriate ones and those should be followed as ordered. They stated they could not say whether the wounds could have been avoided because they were not at the facility all the time to see how consistent the implementation of the pressure relieving measures were and Resident #8 had risk factors including diabetes and limited mobility. It took a long time, but the wounds were responding to treatment. They stated that they did expect pressure relieving measures would continue to prevent recurrence or worsening. During an interview on 6/16/2026 at 11:02AM, Nurse Practitioner #10 stated that they followed Resident #8 since April 2026. They could not speak about the wounds development but stated Resident #8 did have wounds to the sacrum, heel, and ankle. The wounds were improving and the areas should be offloaded to avoid worsening or additional breakdown. 2) Resident #19 had diagnoses including anoxic brain damage (caused by lack of oxygen), cardiovascular accident (stroke) and quadriplegia. The admission Minimum Data Set (assessment tool) dated 06/12/2025, documented Resident #19's cognition was moderately impaired. The resident had no skin issues, was at risk for developing pressure injuries and interventions included devices for the bed and chair. The Braden Scale (assessment to predict risk of pressure injury) dated 05/28/2025 at 8:39 PM, documented Resident #19 was at moderate risk for pressure sores. The nursing head to toe assessment dated [DATE] at 11:26 PM, documented Resident #19's skin was intact. The Activities of Daily Living / Mobility care plan dated 05/28/2025 documented that the resident was dependent on staff for bed mobility and required 2 staff and a mechanical lift for transfers. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335845	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Northeast Ctr for Rehabilitation and Brain Injury		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Grant Avenue Lake Katrine, NY 12449	
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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The At Risk for Impairment of Skin Integrity care plan, dated 05/28/2025 documented the goal was to be free of skin impairment/breakdown as evidenced by intact skin. Interventions included Braden on admission, every week for 4 weeks, quarterly, annually and as needed; incontinent management, observation of skin condition while providing care and weekly skin checks. A nursing note dated 06/01/2025 documented the certified nurse aide notified the nurse that the resident had a fluid filled blister to his right heel. The blister measured 4 centimeters by 2.5 centimeters. The resident's heels were floated. Nursing supervisor, nurse practitioner and wound nurse made aware. Order was received for skin prep. Physician order dated 06/01/2025 documented treatment for the fluid filled blister included soap and water, pat to dry and apply skin prep every day, every shift. The At Risk for Impairment of Skin Integrity care plan was updated 06/01/2025 and documented Resident #19 had a fluid filled blister to the right heel. Additional interventions included an air mattress and off-loading bilateral booties. The Impaired Skin Integrity care plan initiated 06/07/2025 documented Resident #19 had an intact fluid filled blister that measured 7.0 centimeters (length) by 3.0 centimeters (width) with undetermined depth. No other areas of concern noted. Bilateral foot braces remained in place. A nursing note dated 06/09/2025 at 3:25 AM, documented a new open area found on resident's right buttocks area cleansed and left open. Area looked like a blister or pimple that may have been scratched open or popped. The At Risk for Impairment of Skin Integrity care plan was updated 06/09/2025 and documented to put resident back to bed for afternoon nap. A nursing note dated 06/09/2025 at 11:02 PM, documented barrier cream was applied to the right buttock. Wound Care Registered Nurse #56's progress note dated 06/11/2025 at 8:16 AM documented area of concern to right ischium, area noted with abrasions with scant drainage present. Left ischium red and blanchable as well. Both areas noted to be from the brief elastic rubbing on the resident's skin. The floor nurse and nurse practitioner mad aware, physician orders and care plan updated. Physician order dated 06/11/2025 documented treatment for bilateral ischium was soap and water, pat dry and apply Z-Guard every day and as needed. The Impaired Skin Integrity care plan was updated 06/11/2025 and documented pressure relief mattress, and on 06/12/2025 to include back to bed after lunch for afternoon nap/rest. Wound Care Physician #5's note dated 6/16/2025 at 9:04 AM, documented the right heel blister measured 5.0 centimeters by 8.0 centimeters by 0.2 centimeters. The right ischium had moisture associated skin damage and measured 2.3 centimeters by 1.5 centimeters by 0.2 centimeters. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335845	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Northeast Ctr for Rehabilitation and Brain Injury		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Grant Avenue Lake Katrine, NY 12449	
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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Recommendations included air mattress, boots when out of bed, and offload pressure areas. Wound Care Registered Nurse #56's progress note dated 06/16/2025 at 9:00 PM documented wound rounds were made with the physician. Right heel blister treatment was Xeroform/dry gauze/optifoam. The right ischium had moisture associated skin damage and the treatment was changed to plurogel/ dry gauze/ optifoam. Physician orders and care plan updated. The rehab progress note dated 06/19/2025 at 1:24 PM documented the resident's family member expressed concern about the resident not being on an air mattress and the occupational therapy assistant addressed it with the Rehab Director. Wound Care Registered Nurse #56's progress note dated 06/20/2025 at 3:13 PM documented air mattress placed. Review of the electronic medical record had no evidence of wound assessments between 06/16/2025 and 07/02/2025. The Wound Care Nurse Practitioner's report dated 07/02/2025 documented a Stage 3 pressure injury to the right ischial tuberosity originating from moisture associated skin damage. The area was debrided with a curette to remove unhealthy tissue and stimulate wound healing. During an interview on 06/10/2026, the Wound Care Nurse Practitioner stated they started at the facility on 07/02/2025 and Resident #19 had a Stage 3 pressure injury on the right ischial tuberosity. The resident was incontinent and not able to position themselves and that was how moisture associated skin damage would become a Stage 3 pressure injury. They stated they debrided the pressure injury to remove slough (dead tissue) and bacteria and promote healing and ordered hydrogel. They stated the resident could not position independently and preventative measures should include turning and positioning, offloading, barrier cream and changing when incontinent. During an interview on 06/10/2026 at 11:45 AM, Wound Care Registered Nurse #56 stated they saw residents when they got notice from the floor that a resident had a wound. They would look at the specific area and did not do head to toe assessments. They reviewed Resident #19's record and stated they first saw the resident on 06/06/2025 for a heel blister and put bilateral heel boots in place. On 06/11/2025 they saw the resident for an abrasion that developed on the ischium from the brief. They stated they added an air mattress to the care plan on 06/11/2025. They stated Wound Care Physician #5 saw the resident on 06/16/2025 and diagnosed the area as moisture associated skin damage. They stated the resident was seen on 07/02/2025 by the Wound Care Nurse Practitioner and the wound must have progressed as it was documented as Stage 3. During an interview on 06/10/2025 at 12:22 PM, the Director of Maintenance stated they got the request for an air mattress on 06/19/2025. During an interview on 06/11/2025 at 1:55 PM, the Director of Nursing stated the care plan documented an air mattress on 06/01/2025. They stated they did not need a physician order to get an air mattress. They stated on 06/16/2025 the wound care consult documented the right ischium as (continued on next page)		

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335845	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Northeast Ctr for Rehabilitation and Brain Injury		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Grant Avenue Lake Katrine, NY 12449	
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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	moisture associated skin damage and the 07/02/2025 wound consult documented Stage 3 which would mean the wound worsened. The Director of Nursing reviewed the rehab progress note dated 06/19/2025 and stated the air mattress was not in place and it should have been. 10 New York Codes, Rules, and Regulations 415.12 (c)(1)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335845	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Northeast Ctr for Rehabilitation and Brain Injury		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Grant Avenue Lake Katrine, NY 12449	
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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record reviews the facility failed to ensure that needed services were provided to ensure that a resident with limited range of motion and mobility maintained or improved function based on the resident's clinical condition for one of three residents (Resident #6) reviewed for position and mobility. Specifically, range of motion maintenance program was not provided for Resident #6 for two weeks as per Care Plan. The findings include: The Policy for functional support services reviewed 03/2026 documented the facility will provide functional support services as indicated and recommended by the therapy department to prevent decline in mobility, strength, range of motion or functional areas by rehabilitation assistants. Resident #6's diagnosis included chronic respiratory failure, anoxic brain damage, and persistent vegetative state. The admission Minimum Data Set assessment dated [DATE] documented Resident #6 was in a persistent vegetative state and dependent on staff for all cares. The Care Plan for restorative nursing dated 02/04/2026 documented Resident #6 had impaired range of motion, was in a persistent vegetative state. Provide passive range of motion for bilateral upper and lower extremities per schedule. During an interview on 06/04/2026 at 9:51 AM Resident #6's family member stated the facility did not provide range of motion treatments twice a week according to the program they had been informed about. During an interview on 06/04/2026 at 12:31 PM Occupational Therapist #63 stated Resident #6 had not been making any progress after a few weeks of therapy due to no signs of cognition or awareness and could not do any therapy for restorative treatment. All therapy disciplines agreed Resident #6 was not going to make any progress and was added to the restorative program for range of motion. They stated sessions may have lasted 15 to 30 minutes twice a week in addition to what certified nurse aides could provide during cares. During an interview on 06/09/2026 at 12:47 PM Physical Therapy Coordinator #64 stated the functional support program was an extra service provided by the therapy department through a designated certified nurse aide. The therapy department developed the list of residents to receive range of motion care, and the certified nurse aide would document the encounter. The documented treatment dates for range of motion were dated: 01/20/2026, 01/22/2026, 01/27/2026, 02/10/2026, 02/20/2026, 04/14/2026, 04/21/2026, and 05/05/2026 and was not consistently documented for Resident #6. The Physical Therapy Coordinator #54 stated the certified nurse aide that had provided the range of motion care reported they had performed the care but were not documenting each session. 10 New York Code Rules Regulations 415.12(e)(2)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335845	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Northeast Ctr for Rehabilitation and Brain Injury		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Grant Avenue Lake Katrine, NY 12449	
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 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, interviews, and record review during survey, the facility did not ensure all residents were provided the appropriate treatment and services to achieve or maintain as much normal bladder/bowel function for two of two (Resident#1, Resident#38) residents reviewed for bowel and bladder. Specifically, 1) Resident #1 had no documentation that bowel movements or the need for intervention was monitored; and 2) Resident # 38 had an indwelling foley catheter, was diagnosed with a urinary tract infection on 08/28/2024 and on 02/28/2025. Resident # 38's treatment administration record for August 2024 and February 2025, revealed numerous occasions where there was no documented evidence that the facility staff provided catheter care or irrigated the resident's foley catheter. Findings include: Resident #1 had diagnoses that included traumatic brain injury, constipation and dysphagia. The quarterly Minimum Data Set assessment dated [DATE] documented that the resident had moderate cognitive impairment, required substantial assistance with eating and personal hygiene. The resident was incontinent of bladder and bowel. The Bowel/Constipation Care Plan dated 7/17/2025 documented interventions included to monitor bowel status and record daily, record every shift, and report changes. Monitor for constipation (hypoactive bowel sounds, hard stool, abdominal distention, complaints of nausea vomiting, loss of appetite, loose stool). Follow bowel protocol per policy. Bowel Regimen Policy reviewed 6/2026 documented the purpose was to decrease potential for fecal impactions, decrease complications from diarrhea and to maintain comfort. The responsibility of the Certified Nurse Aides was to document and report when the resident had a bowel movement and report to the nurse if a resident has diarrhea or has not moved their bowels. The responsibility of the licensed Practical Nurses and Registered Nurses is to monitor the bowel record and note if a resident has not moved their bowels and is day 3 without a bowel movement. Licensed staff is to check resident for bowel sounds, pain and distention as needed. Administer medication/treatment protocol as appropriate and ordered by the provider. The physician orders dated 8/4/25 documented if no bowel movement in three (3) days; give Milk of Magnesia 400mg/5 milliliters, give 30 cubic centimeters once daily as needed, in four (4) days give Dulcolax suppository rectally 1 daily as needed, in five (5) days give enema rectally once daily as needed. In addition, Sennosides tab 8.6 mg by mouth every day at 9am and 9pm for constipation. Dulcolax suppository once daily every other day at bedtime and Tramadol 50mg 1 tablet every day at 6am, 2pm and 10pm for pain. The Certified Nurse Aide record for resident's bowel movements were reviewed for the month of April 2026 and documented on 04/03/2026 at 5:00am large bowel movement. No other documentation of bowel movements until 4/9 5:00am, loose stool. There were no recorded bowel movements between 4/3 and 4/9 for 6 days (17 shifts). (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335845	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Northeast Ctr for Rehabilitation and Brain Injury		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Grant Avenue Lake Katrine, NY 12449	
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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nurses note dated 4/9/26 documented the residents mother called and reported the resident complained of a stomachache. The resident's abdomen was slightly distended. Last bowel movement was large, loose during the overnight. Nurse Practitioner was made aware, Milk of Magnesia was given right away and if no bowel movement give Dulcolax10 mg. The resident received both and had a large, formed stool. The Nurse Practitioner's note dated 4/9/26 documented a new concern of abdomen being distended, infrequent bowel movements, last adequate was 4/3/26. Had one episode of loose stool raising the concern for overflow diarrhea in a setting of fecal impaction. Clinical picture reflect constipation with possible fecal impaction requiring escalation of bowel regimen. During an interview on 06/09/36 at10:58 AM, Licensed Practical Nurse #66 stated bowel records were very important with brain injury residents. There was a bowel list that came into the computer daily for nurses to check. If a resident did not have a bowel movement for 72 hours, it would show up on the nurse's dashboard. At that point the bowel protocol would be initiated. The resident would get Milk of Magnesia or a suppository. They stated they did not know why there was no documentation and the nurses did not implement the bowel protocol. The resident was at risk for constipation. They stated the certified nurse aides must document meals so they should be doing bowel movements, too. They stated they did not know why that much time had passed and the bowel movements were not checked. They stated it was very important since Resident #1 took Tramadol which was very constipating medication. During an interview on 6/9/26 at 12:55PM, Certified Nurse Aide #46 stated some aides did not care and did not document the care they gave or tasks completed. They stated they always documented the resident weights and bowel movements as the nurses would ask about that. They stated the resident would get medications if they had not had a bowel movement after so many days so they made sure to document bowel movements in the resident record. During an interview on 6/9/26 at 1:05PM, Licensed Practical Nurse Unit Manager #6 stated they got a bowel movement list every morning and gave it to the medication nurses so they knew who needed medications and addressed it on that shift. They stated they did not why nurses were not alerted sooner to Resident #1's lack of bowel movements. During an interview on 6/9/26 at 1:36PM Nurse Practitioner #10 stated the resident had a history of constipation and was on Tramadol which made it worse as it could be very constipating. It was important for staff to document when the resident had a bowel movement. It was expected the staff would document and track bowel movements. 2) Resident # 38 was admitted with a diagnosis of cerebral palsy, hypertension and overactive bladder. The facility policy Clinical Documentation, last revised 5/20/2025, documented that the purpose of documentation is to provide information about the patient that will be used in developing a plan of care and a tool for measuring the quality of care provided to the patient. Documentation should meet the professional standards of clinical practice. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335845	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Northeast Ctr for Rehabilitation and Brain Injury		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Grant Avenue Lake Katrine, NY 12449	
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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The quarterly Minimum Data Set (an assessment tool) dated 04/18/2025, documented the resident had intact cognition, was incontinent of bowel and bladder and had an indwelling foley catheter. The urinary catheter care plan documented to change the catheter as per physician order and to irrigate the catheter as per physician order. The physician orders dated 10/21/2024 documented: - maintenance of catheter, type: foley, catheter size (Fr) 18, balloon size (ml) 10, every day, every shift. - foley catheter care every day, every shift. - irrigate catheter during every evening shift. -change foley catheter drainage bag as per protocol: change foley catheter drainage bag weekly on Tuesday at 9:00 AM. - change catheter monthly at 9:00 AM. The physician order dated 08/21/ 2024 documented a laboratory order request for a urinalysis complete with microscopy. A laboratory result dated 8/28/2024 documented a positive urine result for escherichia faecalis (bacteria), enterococcus coli (bacteria) and klebsiella pneumoniae (bacteria). The physician order dated 02/26/2025 documented a laboratory order request for a urinalysis complete with microscopy. A laboratory result dated 02/28/2025 documented a positive urine PCR result for bacteroides fragilis and klebsiella pneumoniae. A record review of the resident's treatment administration record for the month of August 2024, revealed 13 documentation omissions out of 93 opportunities to document for the physician order for catheter care. A record review for the same month revealed 10 documentation omissions out of 31 opportunities to document for the physician order to irrigate the resident's catheter. A record review of the resident's treatment administration record for the month of February 2025 revealed 12 documentation omissions out of 84 opportunities to document for the physician order for catheter care. A record review for the same month revealed 12 documentation omissions out of 28 opportunities to document for the physician order to irrigate the resident's catheter. During an interview on 06/12/2026 at 1:30 PM Licensed Practical Nurse #57 stated that catheter care included examining the site of insertion checking for redness, discharge or irritation. They stated that they would also check the drainage bag for sediment and the color of the resident's urine to assess if (continued on next page)		

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335845	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Northeast Ctr for Rehabilitation and Brain Injury		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Grant Avenue Lake Katrine, NY 12449	
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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the fluids needed to be increased. Additionally, they stated that if a resident refused catheter care, they would document refused in the treatment administration record and write a brief note stating they refused the care and they were educated on the risks of refusing care. During an interview on 06/12/2026 at 2:02 PM, the Assistant Director of Nursing #1 stated that an X on the treatment administration record meant that the task was not documented. They stated that there was a way for the nurses to review for omissions at the end of their shift so they could complete their documentation. Additionally, they stated that the unit managers were supposed to be checking the record for omissions and holding the nursing staff accountable. They stated that there was no excuse for missing documentation. They stated that if catheter care and catheter irrigation were not performed, it could cause a urinary tract infection. 10 New York Codes Rules and Regulations 415.12(d)(2)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335845	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Northeast Ctr for Rehabilitation and Brain Injury		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Grant Avenue Lake Katrine, NY 12449	
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 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 observation, interview and record review the facility did not ensure the resident was provided the necessary care to maintain, to the extent possible, acceptable body weight for one of two residents (Resident # 1) reviewed for nutrition and hydration. Specifically, daily weights were not implemented as per the 05/06/2026 physician order. The findings include: The policy for weights revised 04/27/2026 documented weights will be completed on neighbors monthly or a frequency recommended by the dietician and ordered by the provider. Nurse Manager's will monitor weights using weight reports in the electronic health record. All weights are documented in the clinical record by the staff. Resident #1 had diagnoses that included traumatic brain injury, constipation and dysphagia. The quarterly Minimum Data Set assessment dated [DATE] documented that Resident #1 had moderate cognitive impairment and required substantial assistance with eating and oral hygiene. The Care Plan for nutrition dated 12/30/2025 documented provide diet per physician order and monitor weight per physician order. The Physician Orders dated 01/07/2026 documented Resident #1 to receive two times portions regular ground diet with nectar thick liquids. The Physician Order dated 05/06/2026 documented daily weight. There was no documented evidence that weights were obtained on May 7,9,13,14,15,16,18,19,20,22,23,24,25, 26, 27,30, and 31. During an observation on 06/02/2026 at 12:14 PM Resident #1 was in their room about to fed by staff. The lunch tray included Ensure Plus nectar thickened, water, juice, two tuna sandwiches, two egg salad sandwiches, mashed potatoes, extra gravy on tray. On return visit at 1:00 PM Resident #1 consumed all food on the tray. During an interview on 06/03/2026 at 9:51AM Certified Nurse Aide #26 stated they were supposed to check the electronic record for all of the resident's information but had not done so. They stated they were not aware that Resident #1 was to be weighed daily, so they had not been weighed. During an interview on 06/03/2026 at 2:01PM Licensed Practical Nurse Unit Manager #6 stated on 05/06/2026 the resident was put on daily weights. They stated from May 11, 2026 - June 03, 2026 Resident #1 had many dates that did not have weights documented. They stated Resident #1 had recent weight loss, and daily weights were a monitoring intervention. They stated all nurses were responsible for making sure weights were being done and were responsible for checking in with certified nurse aides. They stated a lot of times weights were missed because of short staffing. They stated there were a lot of float and agency staff and some of the regular staff don't do what they are supposed to be do. During an interview on 06/03/2026 at 2:31PM the Director of Dietary Services stated Resident #1 had a weight loss in April and was put on daily weights. They stated weights were implemented so any weight loss could be caught early. They stated it was up to nursing to make sure the weights were obtained as ordered. 10 New York Code Rules Regulations 415.12(i)(1)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335845	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Northeast Ctr for Rehabilitation and Brain Injury		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Grant Avenue Lake Katrine, NY 12449	
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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not ensure medications were available to meet each resident's needs for one of five residents (Resident #18) reviewed for medications. Specifically, Resident #18 was admitted to the facility with orders including Clonazepam (a controlled substance) and the facility did not administer the medication or call the pharmacy to notify them the automated medication dispensing cabinet was out of Clonazepam. The physician was notified the medication was out of stock and ordered another medication; there was no documented evidence the substitute medication was given. Resident #18 was admitted to the facility on [DATE] with diagnoses including respiratory failure, anxiety disorder, and was ventilator dependent. A physician order dated 1/12/2026 at 4:17 PM documented Clonazepam 0.5 milligrams via gastrostomy tube, one time for anxiety. The order was discontinued on 01/12/2026 at 9:03 PM and documented not in stock. A physician order dated 01/12/2026 at 7:57 PM documented Clonazepam 0.5 milligrams via gastrostomy tube, from 01/12/2026 every 8 hours for anxiety. A physician order dated 1/12/2026 at 9:03 PM documented Alprazolam 0.5 milligrams via gastrostomy tube, one time for anxiety. The medication administration record did not document the medication was given and there was no other documented evidence the medication was given. The January 2026 medication administration record documented on 01/12/2026 at 10:00 PM, Clonazepam 0.5 milligrams was held, physician aware and not to start until 01/13/2026; and on 01/13/2026 at 7:00 AM was not administered, physician aware, awaiting medication from pharmacy, none in pyxis (automated medication dispensing cabinet). Licensed Practical Nurse #55's progress note dated 01/13/2026 at 8:11 AM, documented Resident #18 was awake most of the shift, continuously ringing the call bell to have brief changed and only needed peri-care twice out of all the times. During an interview on 6/9/26 at 11:50 AM, Registered Nurse #41 stated they admitted the resident on 01/12/26 and received a one time order for Resident #18 for Clonazepam due to anxiety and got it from the automated medication dispensing cabinet. Registered Nurse #41 reviewed the Medication Administration Record and stated the Clonazepam was out of stock and the resident was ordered something else. They stated the Clonazepam was not given until 1:15 PM on 01/13/26 by Licensed Practical Nurse #40. They stated the medication should have been available in the automated medication dispensing cabinet and they did not know if they attempted to get the medication or called the pharmacy. During an interview on 6/9/2026 at 12:31 PM, Assistant Director of Nursing #1 stated the pharmacy made morning, afternoon and evening deliveries daily. They stated the pharmacy was automatically notified when medications were taken out of the automated medication dispensing cabinet and it would be rare if it was not available; it may have happened once or twice. They stated if it was not available, they would call the physician and see if they wanted a substitution medication or to hold the medication. They stated there was a backup pharmacy that they could get medications from within an hour. They stated they would look into what happened with Resident #18 getting Clonazepam. During a follow-up interview on 6/9/2026 at 1:30 PM, Assistant Director of Nursing #1 stated the resident arrived at the facility at 2:59 PM on 01/12/2026 and they thought the one-time order for Clonazepam was written in error. They stated the Clonazepam was ordered to be given on 01/12/2026 at 10 PM and the Medication Administration Record documented the medication was not given, the physician was aware and not to start until 1/13/2026. Assistant Director of Nursing #1 stated the process had been followed as the physician was notified and ordered the medication to be held until 01/13/2026. Assistant Director of Nursing #1 stated they did (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335845	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Northeast Ctr for Rehabilitation and Brain Injury		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Grant Avenue Lake Katrine, NY 12449	
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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not know who notified the physician. They stated calls to the physician and orders to hold should have been documented. They stated they did not know if the pharmacy was called. During an interview on 06/12/2026 at 7:10 AM, Licensed Practical Nurse #55 reviewed Resident #18's electronic medical record and stated they were not sure who notified the physician that the Clonazepam was unavailable. They worked 7 PM to 7 AM and it could have been passed on from the previous shift as they would have written a progress note if they spoke to the physician. They reviewed their progress note and stated the resident was ringing a lot and they wrote a note as this was a behavior and needed to be passed on to other shifts. They stated their note meant many trips were made to the resident's room and ringing that much could be anxiety. During an interview on 06/12/2026 at 7:55 AM, Physician #1 reviewed Resident #18's record and stated they did a history and physical on admission, 01/12/2026. They stated they ordered Alprazolam when the Clonazepam was not available and it should have been documented on the medication administration record. During a telephone interview on 06/17/2026 at 10:46 AM, Pharmacist #1 stated they were the primary pharmacy for the facility and made two deliveries a day. They stated the delivery vehicle left the pharmacy at 2:00 PM and between 1:00 AM and 2:00 AM. They stated the facility was 2 hours and 40 minutes away and they could have other stops on the way. The delivery would arrive at the facility usually sometime around 7:00 AM. They stated if a controlled substance was not available, the facility could call and put in a stat (give immediately) order, and they would do an off-schedule delivery. They stated they did have contracts with some local pharmacies but did not usually use them for controlled substances. They stated the chances of running out of Clonazepam in the automated medication dispensing cabinet was rare and there should have been enough on hand. The pharmacist stated they could run a report and check the status of meds on 01/12/26. The pharmacist ran a report and stated the facility had 9 tablets of Clonazepam on hand in the automated medication dispensing cabinet and did not call for an off-schedule delivery. They stated they did not receive Resident #18's prescription until 8:00 PM on 01/12/2026 and it was delivered at 9:33 AM on 01/13/2026. 10 New York Codes, Rules, and Regulations 415.18(a)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335845	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Northeast Ctr for Rehabilitation and Brain Injury		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Grant Avenue Lake Katrine, NY 12449	
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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview during survey, the facility did not ensure necessary dental services were provided in a timely manner for one (1) of two (2) residents (Resident #7) reviewed for Dental Services. Specifically, Resident #7 was admitted to the facility on [DATE] and not provided routine dental services. The findings include: The facility policy titled Use of Outside Resources, last revised 06/2025, documented the facility will provide residents with a full range of services performed by qualified and capable people when such individuals are not employed by the facility, including Dental Services, requiring services to be provided on a timely basis. Resident #7 was admitted with diagnoses including but not limited to Cerebellar stroke syndrome, dysphagia, and need for assistance with personal care. The admission Minimum Data Set (resident assessment tool) dated 04/08/2026 documented Resident #7 had intact cognition and required maximal assistance for oral hygiene. There was no documented evidence of a Dental care plan for Resident #7. During an observation on 06/02/2026 at 10:58 AM, Resident #7 was in the therapy room reclined in their chair. Their mouth appeared dry, peeling lips and teeth appeared to have a white coating. During an interview on 06/03/2026 at 12:14 PM Licensed Practical Nurse Unit Manager #27 stated Residents were usually seen by the Dentist within the first six (6) weeks of admission, they were automatically seen with or without an order. Resident #7 had not been seen. During an interview on 06/03/2026 at 12:26 PM, Medical Secretary #28 stated the Dentist provided services twice a month. A list of residents that needed to be seen by the dentist was sent from the nursing department for Medical Secretary #28 to add to the dentist schedule. Resident #7 was readmitted from the hospital on [DATE], and an email on 04/06/2026 was sent from the unit secretary to Medical Secretary #28 with the request to add Resident #7 to the dental list. Medical Secretary #28 provided an email dated 04/27/2026 that showed Resident #7 was on the dental schedule to be seen by the dentist on 04/28/2026. They stated the Dentist sometimes did not always see everyone on the list. During a phone interview on 06/08/2026 at 9:16 AM, the Dentist stated they prioritized residents according to emergency situations and pain, the facility facilitates the list of priorities for them. The Dentist stated they try to see new admissions within 30 days for the initial exam. Most likely Resident #7 was not seen because of three other residents requiring extractions which took 30-40 minutes and another eight (8) that were consulted for pain. This did not allow time for any other exams as they were encouraged by their supervisor to complete the work at the facility in 2-3 hours. 10 New York Codes, Rules, and Regulations 415.17(a-d)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335845	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Northeast Ctr for Rehabilitation and Brain Injury		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Grant Avenue Lake Katrine, NY 12449	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interviews conducted during the abbreviated survey, the facility did not ensure that the food was prepared and served in accordance with professional standards for food service safety. Specifically, staff were observed not wearing hair restraints and beard guards while in the kitchen. The findings include: The revised policy 06/12/2025 titled Kitchen Staff Personal Hygiene and Health documented employees dress code of hairnet or baseball hat with proper use of hair restraints are to be always used in the kitchen area and beard guards. During a visit to the kitchen on 07/21/2026 at 12:40 PM an observation and interview of a dietary aide with no hair restraint walked across the kitchen to obtain a hair restraint for the surveyor. They stated they forgot to put their hair restraint back on after lunch. An observation of a dietary aide working on the tray line with a full beard and no beard guard, and the Assistant Food Service Director had a small beard/goatee with no beard guard. During an interview at this time the Food Service Director stated the facility did not use beard guards in the kitchen and the Assistant Food Service Director seemed surprised that they would also require a beard guard on their small beard/goatee. The Food Service Director made a note that they would order beard guards. 10 New York Codes, Rules, and Regulations 415.14(h)		