

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335858	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/24/2025
NAME OF PROVIDER OR SUPPLIER Woodland Pond at New Paltz		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Woodland Pond Circle New Paltz, NY 12561	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40686</p> <p>Based on observation, interview, and record review conducted during the recertification and abbreviated (NY00371165 and NY00370838) survey from 4/21/2025 to 4/24/2025, the facility did not ensure a resident unable to carry out activities of daily living received the necessary services to maintain good personal hygiene. This was evident for 2 (Resident #6 and #28) of 3 residents reviewed for activities of daily living. Specifically, 1) Resident #6 reported long wait times to receive assistance with incontinence care and personal hygiene, and 2) Resident #28 was dependent on assistance for activities of daily living and had to wait 66 minutes on 2/1/2025 to receive incontinence care.</p> <p>The findings are:</p> <p>The facility policy titled Activities of Daily Living dated 4/22/2025 documented resident activities of daily living performance skills would be assessed and a care plan would be completed.</p> <p>1) Resident #6 had diagnoses of left femur fracture and altered mental status.</p> <p>The Quarterly Minimum Data Set (resident assessment) dated 1/16/2025 documented Resident #6 had moderately impaired cognition, required 1-person assistance with toileting and was always incontinent.</p> <p>The Significant Change Minimum Data Set, dated dated [DATE] documented Resident #6 had moderately impaired cognition, and was totally dependent on 1 to 2 staff for assistance with incontinence care.</p> <p>The Comprehensive Care Plan related to activities of daily living initiated 4/2/2025 documented Resident #6 required assistance with incontinence care, dressing, and personal hygiene due to a recent left hip fracture and would remain clean, neat, dressed appropriately, and free of body odor.</p> <p>The Nursing Instructions as of 4/2025 documented Resident #6 was dependent on staff for clothing management and post-voiding hygiene during incontinence care.</p> <p>On 4/21/2025 at 3:35 PM, Resident #6's Designated Representative was interviewed and stated there were not enough staff to attend to Resident #6's activity of daily living needs in a timely manner. They stated Resident #6 rang the call bell for assistance and waited over 30 minutes at times for assistance, especially on the overnight shifts.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/21/2025 at 5:10 PM, Resident #6 was observed in bed in their room. The call bell button was observed on their recliner out of reach. Resident #6 stated their care was inconsistent and they had to wait extended periods of time to have their call bell answered or to receive incontinent care. The 7 PM to 7 AM shift was short of staff and were unable to provide care timely. Resident #6 stated they were placed in bed today after they received physical therapy and had not received care from a Certified Nurse Aide since then.</p> <p>On 4/24/2025 at 10:45 AM, Resident #6 was observed in their room in bed wearing an incontinence brief and t-shirt. Resident #6 stated the Certified Nurse Aide stopped by to introduce themselves this morning and stated they would be back to provide them with care. Resident #6 stated they did not receive assistance with incontinence care, personal hygiene, or dressing yet for the day.</p> <p>On 4/24/2025 at 11:04 AM, Certified Nurse Aide #9 was interviewed and stated they started their shift at 7 AM and were assigned to Resident #6. Certified Nurse Aide #9 stated they went to introduce themselves to Resident #6 and stopped by the resident's room but have not been able to provide the resident with activity of daily living care including toileting, grooming, or personal hygiene. Certified Nurse Aide #9 stated they were assigned 9 residents and 7 residents on their assignment required the assistance of 2 people to perform activities of daily living. The night shift was assigned to make sure 1 resident on Certified Nurse Aide #9's assignment received morning cares and was transferred out of bed. Certified Nurse Aide #9 stated they had to provide morning cares and get up 8 residents this morning, including Resident #6, and assist with breakfast service. Certified Nurse Aide #9 stated they were assigned to the dining room to assist with feeding residents for breakfast. They were unable to provide care to 3 of their assigned residents, including Resident #6, yet today. Incontinent residents who require assistance with toileting and/or changing their incontinence brief should be checked by staff every 2 to 4 hours. Certified Nurse Aide #9 stated they communicate with the night shift when they start their shift to receive report about residents but did not know when Resident #6 last had their incontinence brief changed. Certified Nurse Aide #9 stated there were 2 Certified Nurse Aides staffed on the night shift and more tasks and work were placed on the day shift aides when they started their shifts in the morning.</p> <p>On 4/24/2025 at 12:47 PM, Licensed Practical Nurse #10 was interviewed and stated they were 1 of 2 medication nurses for the unit. The facility used to staff 3 medication nurses for the day shift but now the facility only staffed 2 medication nurses. There were 4 aides assigned to the day shift. The licensed nurses on the unit tried to help the aides with attending to residents when they were able to, but the licensed nurses needed to ensure that medications were given on time. Licensed Practical Nurse #10 stated they answered call bells but if a resident needed activity of daily living assistance, Licensed Practical Nurse #10 would let the resident know they needed to wait for when their aide had time to come assist them. Licensed Practical Nurse #10 stated they would assist the aides when they could if they had time after their assignment was completed. Licensed Practical Nurse #10 stated Resident #6 required the assistance of 2 people for cares and used a mechanical lift to transfer out of bed. Resident #6 also needed 2 people to assist when turning and positioning in bed. The unit had 19 residents who required 2 people and a mechanical lift to transfer in and out of bed. The assignment could be overwhelming for the night shift to address everyone since there were only 2 aides assigned to provide care to all the residents on the unit at night.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/24/2025 at 3:57 PM, the Director of Nursing was interviewed and stated the 2 Certified Nurse Aides assigned to the night shift were able to address all resident care needs adequately. Any of the licensed nurses assigned to the night shift were able to assist the aides with providing resident care. The licensed nurses were expected assist the aides but were not formerly assigned residents to care for on the overnight shift. It was not acceptable for a resident to still be waiting for morning activity of daily living care at 11 AM. None of the residents have complained that the facility was short of nursing staff or that they have not received care timely. The Director of Nursing and Administrator monitored call bell response times and did not identify any concerns with resident care needs being addressed. None of the staff have complained that their assignment was overwhelming. The Director of Nursing stated they felt it was reasonable for 2 aides to address the needs of 19 residents with total care needs overnight because the licensed nurses assisted with providing residents with care.</p> <p>51214</p> <p>2) Resident #28 with diagnoses that included, but not limited to, cerebral infarction, hemiplegia, and aphasia.</p> <p>The Annual Minimum Data Set, dated dated [DATE] for Resident #28 documented the resident had moderately impaired cognition, maximum assistance to dependent for activities of daily living.</p> <p>The Activities of Daily Living Care Plan dated 10/7/2024 for Resident #28 documented dependent on staff for incontinence care.</p> <p>The Quarterly Minimum Data Set data set dated [DATE] documented Resident #28 had moderately impaired cognition and required maximum assistance for activities of daily living.</p> <p>A facility investigation dated 2/1/2025 documented that on 2/1/2025 at 2:22 PM Administration was notified by the Certified Nursing Aide, assigned to Resident #28, that Resident #28 was crying, in need of incontinence care, and stated that they were not tended to in a long time. The timeline provided from the investigation documented that Resident #28 initiated the call bell at 10:53:55 AM and the bell was answered at 12:00:52 PM after ringing for 66 minutes and 57 seconds. Incontinence care was provided at approximately 12:20 PM.</p> <p>During an interview on 04/23/25 at 12:08 PM, the Director of Nursing stated that they were currently auditing the call bell response time. They stated Resident #28 had to wait for 66 minutes to receive incontinence care and that a wait time of more than 20-25 minutes was unreasonable.</p> <p>10 NYCRR 415.12(a)(3)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51214</p> <p>Based on observation, interview, and record review during the abbreviated (NY00370838 and NY00371165) and recertification surveys from 4/21/2025-4/24/2025, the facility did not ensure sufficient nursing staff to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically, 1). multiple residents and family members complained about long wait times after initiating the call bell, 2). Resident #28 had to wait 66 minutes on 2/1/2025 to receive incontinence care, 3) Resident Council attendees reported long wait times to receive assistance from staff for activity of daily living, and 4) Resident #6 was observed waiting an extended period of time for assistance with morning care due to staff inability to manage their assignment, refer to F677.</p> <p>The findings included:</p> <p>The policy titled Staffing documented provide adequate staffing to meet needed care and services for resident population.</p> <p>1) The Call Bell Logs from October 2024-January 2025 documented 196 alarms in October, 104 alarms in November, 178 alarms in December, and 151 alarms in January took more than 30 minutes for a response. Call bell Logs included but were not limited to the following examples: Friday October 11, 2024 at 8:53 AM, the call bell in room [ROOM NUMBER] was answered after 56 minutes, Saturday October 26, 2024 at 7:43 PM the call bell in room [ROOM NUMBER] was answered after 78 minutes, Thursday October 31, 2024, at 7:29 PM, the call bell in room [ROOM NUMBER] was answered after 72 minutes, Saturday November 2, 2024 at 7:06 AM, the call bell in room [ROOM NUMBER] was answered after 73 minutes, Sunday November 3, 2024 at 8:04 PM, the call bell in room [ROOM NUMBER] was answered after 77 minutes ,Thursday November 7, 2024 at 05:18 AM the call bell in room [ROOM NUMBER] was answered after 74 minutes, Thursday December 5, 2024, at 7:33 PM the call bell in room [ROOM NUMBER] was answered after 74 minutes, Friday December 13, 2024 at 10:01 AM the call bell in room [ROOM NUMBER] was answered after 117 minutes, Thursday December 19, 2024 at 04:20 AM the call bell in room [ROOM NUMBER] was answered after 82 minutes, Monday January 19, 2025, at 6:26 PM the call bell in room [ROOM NUMBER] was answered after 71 minutes, and Wednesday January 22, 2025 at 10:38 AM the call bell in room [ROOM NUMBER] was answered after 74 minutes.</p> <p>2) A facility investigation dated 2/1/2025 documented that on 2/1/2025 at 2:22 PM Administration was notified by the Certified Nursing Aide, assigned to Resident #28, that Resident #28 was crying, in need of incontinence care, and stated that they were not tended to in a long time. The timeline provided from the investigation documented that Resident #28 initiated the call bell at 10:53:55 AM and the bell was answered at 12:00:52 PM after ringing for 66 minutes and 57 seconds. Incontinence care was provided at approximately 12:20 PM. (See F677)</p> <p>3) During the Resident Council meeting on 4/22/2025 at 11:10 AM, Residents #9, #15, and #30 stated the night shift had problems as 40 residents was too much for 2 Certified Nurse Aides. All residents in attendance reported the night shift staff were not able to attend to resident activity of daily living needs and that many waited until 7 AM-7 PM to receive assistance with incontinence care and to be transferred to bed.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During the Resident Council meeting on 4/22/2025 at 11:51 AM Resident #15 stated during the overnight shift there have been 2 Certified Nurse Aides and during the day shift there were 3 Certified nurse Aides. They stated the day shift staff were used to get them in bed because they would have to wait a very long time to go to bed with the night shift starting at 7 PM.</p> <p>During the Resident Council meeting on 4/22/2025 at 11:51 AM, Resident #19 and Resident #33 stated residents were told to urinate in their brief because they had not had a bowel movement.</p> <p>During an interview on 4/23/2025 at 12:08 PM, the Director of Nursing stated that they felt staffing numbers were adequate to provide the care needed for their residents. The stated Resident #28 had to wait for 66 minutes to receive incontinence care and that a wait time of more than 20-25 minutes was unreasonable and was the cut off for their audit.</p> <p>During an interview on 4/24/2025 at 10:33 AM Resident #18's family member expressed concern over the time it took for staff to answer call bell/s. They stated when staff answered they frequently stated they needed a second person, left and did not return for 20-30 minutes.</p> <p>During an interview on 4/24/2025 at 11:57 AM Certified Nursing Assistant #8 stated there were usually 3 Certified Nurse Aides on the unit during evening/night shift, occasionally there were only two. They stated when there was only two, the assignment was not easy, but doable, especially with all the residents that required a lift for transfers. They stated nurses assisted with resident care and answering call bells, but the extra nurse was not given an aide assignment to make it a three-way split, it remained a two-way split.</p> <p>10 NYCRR 415.13</p> <p>40686</p>		