STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335860	A. Building B. Wing	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eddy Village Green at Beverwyck	40 Autumn Drive Slingerlands, NY 12159

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 - 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews conducted during survey, the facility failed to ensure residents were free from neglect and abuse for two (2) (Resident#7 and Resident #26) of seven (7) residents reviewed for abuse and neglect. Specifically, (a) on 07/21/2025, Resident #7 Comprehensive Care Plan intervention to take resident to the bathroom immediately after dinner due to resident's high risk for fall was not implemented and Resident #7 sustained a fall with injury (an abrasion to the left lateral knee area and a bruise to their left inner thigh), and (b) on 05/11/2025, Resident #26's hipsters (pants with padded hips to help decrease the chances of injury) which were a care planned intervention to be placed on the resident daily, were not put on Resident #26 and Resident #26 fell from their wheelchair. Resident #26 sustained a change in status causing their weight bearing status to change from non-weightbearing on their right lower extremity (when the right foot/leg must not touch the floor or support any body weight) to full non-weight bearing status (when one cannot put weight on an injured limb and it must be fully supported at all times). This resulted in actual harm to Resident #7 and Resident #26 that was not Immediate Jeopardy. Findings include:Facility policy and procedure titled Abuse Prevention and Investigation Policy effective 03/25/2025, documented residents had the right to be free from verbal, sexual, physical, and mental abuse; neglect, and mistreatment. Abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also included the deprivation of goods or services that were necessary to attain or maintain (physical, mental, and psychosocial well-being. It included verbal abuse, sexual abuse, physical abuse, and mental abuse. Neglect was defined as failure to provide timely, consistent, safe, adequate and appropriate services, treatment, and care necessary to avoid physical harm, mental anguish, or mental illness, such as nutrition, medication, therapies, sanitary clothing and surroundings, and activities of daily living. Resident #7 Resident #7 was admitted to the facility with diagnoses of unspecified dementia, with psychotic disturbance (cognitive decline combined with hallucinations or delusions where the specific type of dementia is not defined), unspecified glaucoma (diagnosis in which glaucoma, a group of eye diseases that damage the optic nerve leading to irreversible vision loss if not treated, but the specific type has not been documented), and benign prostatic hyperplasia without lower urinary tract symptoms (noncancerous enlargement of the prostate gland due to aging and hormonal changes). The Minimum Data Set (a resident assessment tool) dated 03/27/2026, documented the resident rarely/never made themselves understood and rarely/never had the ability to understand others. The Comprehensive Care Plan with focus Alteration in elimination as evidenced by bowel incontinence, functional incontinence, urinary tract function sufficiently intact, but cannot remain continent due to external factors (mobility, cognition, diuretic), BPH (benign prostatic hyperplasia), initiated 12/30/2020, documented as interventions, toilet upon waking, 11:30 AM, even if family present please take resident in and by 3:30 PM and after dinner, before bed and check and change twice during the night initiated 04/10/2024, updated 02/02/2026 and take me to the bathroom as soon as I am finished with dinner as I am at high risk for falls as I will attempt to take myself to (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Actual harm Residents Affected - Few	the bathroom as soon as I finish my dinner meal initiated 01/22/2024. The Comprehensive Care Plan with focus Resident may have potential for physical/psychological injury/victim of abuse related to aggressive behaviors of another resident initiated 12/29/2020 documented as an intervention assist me directly after meals as I will wheel myself right to my room for toileting or attempt to get into bed initiated 02/06/2024. The Comprehensive Care Plan with focus Safety awareness deficit related to decreased strength/endurance, history of falls, seizure initiated 12/30/2020 documented an intervention do not place stand lift outside of my door and take me to the bathroom as soon as I finish my dinner initiated 01/22/2024. Resident #7's Kardex (a quick reference tool used to summarize essential resident information and care plan) followed by certified nurse aides documented under toileting section toilet upon waking, 11:30AM, even if family present please take them in and by 3:30 PM and after dinner, before bed and check and change twice during the night on 04/10/2023 and under the safety section do not place lift outside of my door and take me to the bathroom as soon as I finish my dinner initiated 01/22/2024. It also documented in this section assist me directly after meals as I will wheel myself right to my room for toileting or attempt to get into bed. The Facility Investigation dated 07/24/2025 documented on 07/21/2025 at 8:15 PM, Resident #7 was observed by certified nurse aides to be on the floor in their room. The resident had an abrasion to their left lateral knee area (left side of the knee) and a bruise to their left inner thigh. Upon house camera review and statements from staff, it was noted Resident #7's care plan was not followed, and the resident was not assisted to the bathroom after dinner per plan of care. The certified nurse aides responsible for care and oversight of the resident were terminated, Resident #7's family member was updated on findings, the incident was reported to the Department of Health, education was provided to all staff regarding following care plans, highest risk for falls individuals were reviewed in the house, and staff were instructed not to wash dishes in the evening until all residents have been taken to the bathroom and/or assisted to bed. During an observation on 04/28/2026 at 6:01 PM, Resident #7 was sitting in their wheelchair at a table in the dining area. They completed their dinner and had a cup of ginger ale in front of them. At 6:10 PM, Certified Nurse Aide #5 wheeled Resident #7 from the dining area to their room. Registered Nurse #5 approached Resident #7's room. Certified Nurse Aide #5 left the room, and Registered Nurse #5 administered medications to Resident #7 until 6:30 PM. At 6:30 PM, Registered Nurse #5 wheeled Resident #7 out of their room into the common living area with other residents who were watching television. Resident #7 was observed by Surveyor from 6:01 PM through 6:59 PM and was not observed to be taken to the bathroom after dinner. During an interview on 04/28/2026 at 6:51 PM, Certified Nurse Aide #5 stated after dinner, residents were toileted and assisted with getting ready for bed. The Kardex for each resident was hung in the closet and it let them know how to provide care for the residents. They checked the Kardex daily to see if there were any changes to it. They stated Resident #7 was dependent upon staff for assistance with toileting, and they were toileted every two (2) hours. They stated Resident #7 was supposed to be taken to the toilet after dinner, but they were not taken to the toilet once the resident finished dinner on this date. During an interview on 05/01/2026 at 1:25 PM, Director of Nursing #1 stated the Kardex's for residents were kept in their closet and they should be checked by the certified nurse aides at the beginning of each shift before they provide care for a resident. If a resident were to have a specific time they were to be toileted, it was expected to be done at that time. Resident #7 should be taken to the bathroom after meals. This resident was taken to use the bathroom after meals because when they were done eating, they began to propel themselves to the bathroom. There was a reportable incident of a fall for Resident #7 that previously occurred in which the care plan for the resident was not followed and they were not toileted after completion of dinner. Resident #26 Resident #26 was admitted with diagnoses of Alzheimer's disease (a progressive, irreversible neurodegenerative disorder that affects memory, thinking, and behavior), insomnia (inability to sleep), and age-related osteoporosis (a disease characterized by decreased bone mass and strength, leading to brittle bones that break easily, particularly in the hip, spine and wrist. The Minimum Data Set, dated [DATE], documented the (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	resident was rarely/never understood, rarely/never understood others and was completely cognitively compromised. The Comprehensive Care Plan for Osteoporosis date initiated 05/01/2025 and last revised 02/26/2026, documented that Resident #26 had a history of pathological bone fracture related to osteoporosis and had a fall on 05/11/2025. The documented interventions included non-weight bearing right lower extremity. The Comprehensive Care Plan for Safety Awareness, date initiated 06/14/2023 and last revised 05/14/2025, documented the resident had safety awareness deficit related to confusion/decreased memory, dementia, history of falls, limited mobility. This care plan documented the resident had a slip/fall from recliner on 07/07/2024 and an intervention initiated on 07/08/24 documented to apply clean hipsters daily. Resident #26's Kardex as of 05/06/2025 documented under the section for safety to apply clean hipsters daily. A fall follow-up note dated 05/11/2025 at 2:41 PM documented that Resident #26 was left in their wheelchair after lunch sitting in the common area, Resident #26 did not have hipsters on as stated in care plan as all hipsters were in laundry, wheelchair was not in locked position. Order received for left hip x-ray and order to keep resident in bed until results of x-ray returned. Facility Situation, Background, Assessment, Recommendation (SBAR) Report dated 05/12/2025 documented on 05/11/2025, Resident #26 had a fall in the living room close to 2:00 PM. The resident's routine was to be taken to the bathroom after lunch and then sit in a recliner in the living room. On 05/11/2025 at 1:51 PM, Resident #26 was seen on camera standing up and tripping over the wheelchair footrests into another resident's wheelchair and onto the floor. An x-ray was ordered to the left hip and pelvis. Impression: moderate degenerative changes bilateral hips. Concern for fracture of right hip (identified on 04/29/2025 prior to the fall) with signs of impaction, varus angulation of right femur (a deformity where the femur bows outward). No evidence of left hip fracture. Recommend CT (computed tomography) of the pelvis for further investigation (Health status note documented previously completed x-ray to right hip and pelvis on 04/29/2025 indicated osteopenia [a condition characterized by lower than normal bone mineral density]. Cortical irregularity along the lateral aspect of the femoral neck concerning for a small subchondral nondisplaced fracture [a hairline crack in the bone directly beneath joint cartilage where the bone fragments remain aligned]. A health status note dated 05/11/2025 at 7:37 PM documented that Medical Provider #1 and Resident #26's family member felt that based on x-ray results, it was not pertinent to send resident to hospital at that time. Resident #26 was made non-weight bearing and a mechanical lift was to be used when getting the resident out of bed. An orthopedic consult dated 05/14/2025 documented Resident #26 was seen for follow up x-ray post fall 05/11/2025. Findings documented increased pain with right hip logroll (a physical examination technique used to evaluate hip pathologies) compared to last week (Resident #26 was seen by orthopedics on 05/01/2025 prior to the incident). Diagnosis documented suspected right hip fracture with increased pain. Recommendations included non-weight bearing status right lower extremity, there has been advancement of symptoms, choices were to go to hospital for advanced imaging (computed tomography, magnetic resonance imaging) or commit to long term non-weight bearing status. Family to discuss. A communication/family note dated 05/15/2025 at 2:39 PM documented that the facility spoke to family, and they had decided against pursuing further diagnostic testing and surgery. The family understood that the resident would be non-weight bearing with comfort as the goal. The family representative had spoken with other family members who were medically trained, and they requested certain medications be given for pain management. Resident #26 was using the (brand name) chair (a specialized, durable medical wheelchair designed for comfort, pressure redistribution, and positioning) for out of bed seating and reported that they were comfortable and had no evidence of pain noted while seated in the chair. Medical Director #1 and Physical Therapy notified of family wishes. The Facility Investigation report dated 05/15/2025 documented that Certified Nurse Aide #6 assigned to provide care to the resident on 05/11/2025, reported they did not place the hipsters on Resident #26 when they got the resident up because the hipsters were not in the room at the time and the certified nurse aide did not want to leave the resident in their room unattended. Certified Nurse (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Aide #6 stated that they knew there was a clean pair for the resident in the laundry room and planned to put them on the resident after lunch when they took Resident #26 to the bathroom. The house cameras were reviewed which showed Certified Nurse Aide #6 going in to provide care to the resident at 9:28 AM. Certified Nurse Aide #6 left the room twice during that time, once to retrieve the resident's wheelchair in the living room and once to throw away garbage and was seen on camera stopping to speak to a resident family member. The house camera also revealed an agency certified nurse aide going into the resident's room and sitting in the chair in the corner of the room as the door was open. At no time, did the caregiver ask the other certified nurse aide to go retrieve the hipsters located in the laundry room which is located on the same level and less than 60 feet from the resident's room. Documentation of the actions taken as a result of the incident were that hipsters would be on the treatment record for residents who wear them to ensure a nurse was checking for placement. Additional hip protectors have been ordered to ensure every resident had at least two (2) pairs so there was a pair in their room at all times. The certified nurse aide responsible for providing care to the resident on 05/11/2025 7:00 AM to 3:00 PM shift was terminated from employment. The nurse would confirm that the hipsters were being worn when the residents got up in the morning. During an interview on 05/01/2026 at 3:23 PM, Director of Nursing #1 stated regarding the incident on 05/11/2025, Certified Nurse Aide #6 had ample opportunity to get hipsters from the laundry. The laundry room was not far from the resident's room, maybe 20 feet. They could have asked another aide to get the hipsters for them, which would have been the expectation. During an interview on 05/01/2026 at 2:48 PM, Administrator #1 stated if a resident had needs that were care planned for, such as toileting the resident after dinner, the care plan should be followed, and the intervention should be done. 10 New York Codes, Rules, and Regulations 415.4

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on observation, interview, and record review conducted during a survey, the facility failed to report all alleged violations involving abuse, neglect, and injuries of unknown source immediately, but not later than two (2) hours after the allegation was made, to the administrator of the facility and to other officials (including to the State Agency) for two (2) (Resident #s 12 and 27) of five (5) residents reviewed. Specifically, (a) Resident # 12 reported an incident with alleged abuse on 01/05/2026 at 9:00 PM. This incident was reported to the Department of Health on 01/06/2026 at 9:59 AM. (b) Resident # 27 reported an incident with alleged abuse on 03/30/2025 at 10:09 AM, which was reported to the Department of Health on 03/30/2024 at 6:42 PM. Findings Include:The facility's Policy and Procedure dated 03/25/2025 titled Abuse Prevention & Investigation documented, the incident must be reported immediately upon witnessing or learning of a suspected allegation of abuse to a direct supervisor, charge nurse, administrator, Director of Nursing Services, or other appropriate designee without fear of retaliation and regardless of whether the reporting staff member feels the allegation is credible. As per state laws, rules, and regulations all staff have the obligation to report incidents of abuse to the Department of Health. A report to the Department of Health must be made immediately, but no later than two (2) hours after an allegation of abuse is made. Record review revealed a nursing progress note, dated 01/05/2026 at 9:19 PM, documented a bruise on Resident #12's left upper extremity. Record review revealed the allegation of abuse to Resident #12 was sent from the facility to the New York State Department of Health as a Facility Reported Incident on 01/06/2025 at 9:59 AM.Investigation of Abuse statement by Certified Nurse Assistant #2 dated 04/01/2025, documented while they were preforming routine morning care with Resident #27 on 03/30/2026 around 8:00 AM, they were told by the resident their arm was hurting because someone beat them up the night before.Record review revealed the allegation of abuse to Resident #27 was sent from the facility to the New York State Department of Health as a Facility Reported Incident on 03/30/2025 at 6:42 PM. The incident was documented as being initially reported to staff on 03/30/2025 at 8:00 AM.During an Interview on 05/01/2026 at 10:37 AM, Certified Nurse Assistant #3 stated that as soon as the resident was safe, they reported suspected abuse or statements about abuse to the supervisor and/or nurse. They stated abuse allegations needed to be reported to the Department of Health within two (2) hours. During an interview on 05/01/2026 at 12:08 PM, Registered Nurse #1 stated that any allegations of abuse should be reported immediately as well as reported to Department of Health within two (2) hours. The time to report to the Department of Health started with the first employee that was informed of the allegation. During an interview on 05/01/2026 at 1:26 PM, Director of Nursing #1 stated all abuse allegations must be reported to the Department of Health within two (2) hours.During an interview on 05/01/2026 at 2:48 PM, Administrator #1 stated if a resident reported abuse or a staff member suspected it, it should be reported to nurse immediately. The nurse would then report to the on-call person, which typically was themselves or an administrative nurse. If they were not the on-call person, the on-call nurse would then notify them. They further stated staff knew how to report to the Department of Health if they could not reach administration, and that the report to the Department of Health needed to be made within two (2) hours.10 New York Codes, Rules, and Regulations 415.4(b)(2)