

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335860	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2026
NAME OF PROVIDER OR SUPPLIER Eddy Village Green at Beverwyck		STREET ADDRESS, CITY, STATE, ZIP CODE 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	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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on record review, observations, and interviews during the survey, the facility failed to ensure that food was stored, prepared, distributed, or served following professional standards for food service safety in the Main Kitchen and in the house kitchens for House 21 and House 31. Specifically, proper labeling/dating of open items was not followed, and expired food items were found stored ready for use in the refrigerators and freezers. Findings include:Policy titled, Production, Purchasing, Storage; subject Food and Supply Storage, revised 01/2026, documented all food, non-food items and supplies used in food preparation shall be stored in such a manner as to prevent contamination to maintain the safety and wholesomeness of the food for human consumption. Foods past the use by, sell by, best by, or enjoy by date should be discarded. Cover, label, and date unused portions and open packages. Use the Medvantage/Freshdate labeling system or complete all sections of an orange label. Products are good through the close of business on the date noted on the label. Date and rotate items; first in, first out. Discard food past the use-by or expiration date. Food prepared in-house and then stored frozen should be kept no longer than three months. Commercially produced foods may be held frozen until the manufacturer's expiration date, or for 3 (three) months if no expiration date on the package. Once the packaging around the food has been opened, food must be used within 3 (three) months. Observations conducted on 04/20/2026 from 10:04 AM to 10:55 AM revealed the following: The following items were found to have been opened and without proper labeling and/or dating or past their use by date in the Main Kitchen refrigerator:A package of American cheese.A partially used package of a head of iceberg lettuce.1 (one) bag of spinach and 2 (two) unopened bags of spinach.1 (one) head of fennel, unwrapped with no use by date. It was unclear if the fennel was used.A package of strawberries.A bag of carrots.A bag of turnips .A bag of onions .2 (two) bags of cilantro.A box with 7 (seven) individually wrapped cucumbers were found with no use by date.The following items were found to have been opened and/or without proper labeling and/or dating or past their use by date in the Main Kitchen freezer:Four (4) bags of blue cheese crumbles.An opened bag of blueberries.An opened bag of sausage crumbles.An opened bag of beef/veal patties.An unidentifiable piece of meat wrapped in clear plastic wrap and labeled beef dated 4/20 (year not included) for today's date.A wrapped package of turkey meatloaf dated 08/11/2025 with a discard date of 10/10/2025.A plastic container labeled tofu marked 6/17/2025 with a use by date of 12/14/2025.A bag of opened peas.A bag of opened corn kernels.5 (five) turkey breasts wrapped in plastic wrap in a plastic bin. The box they came in was discarded. The items were not marked with a use by date.The following items were found opened without proper labeling and/or dating or past their use by date in the pantry in the main kitchen:A bag of tortilla chips marked open 4/18/2026 with a discard date of 4/22/2026.An open and a closed package of dry bread stuffing mix wrapped together in plastic wrap with an opened date of 2/11/2026 and a discard date of 2/14/2026.The following item was found without proper labeling and/or dating or past their use by date in the refrigerator in the kitchen in House #31:Sliced tomatoes in a plastic container covered with plastic wrap. There was no label that indicated a date the item was first used or when to discard the item by.The following items were found without proper labeling and/or dating or past their use by date in the freezer in the kitchen in House #31:An opened package of waffles, an opened package of sausage patties, an opened package of sausage links, an opened bag of pre-made ready to bake cookies, an opened container of chocolate marshmallow ice cream. All of these items were not labeled with the date the items were opened or the date to use the items by.The following item was found without proper labeling and/or dating or past their use by date in the pantry/storage area behind kitchen in House #31:A plastic container with dry cereal date opened 8/26/2025, discard date of 2/22/2026.The following item was found without proper labeling and/or dating or past their use by date in the refrigerator in the pantry/storage area behind the kitchen in House #31:An opened package of meat patties with no opened or use by date.An unopened container (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	of whole milk with a best by date of April 23, 2026. The following item was found opened without proper labeling and/or dating or past their use by date in the freezer in the pantry/storage area behind the kitchen in House #31:An bag of premade meatballs with no opened or use by date.The following item was found opened without proper labeling and/or dating or past their use by date in the freezer in the pantry/storage area behind the kitchen in House #21An bag of ready to bake cookies with no opened or use by date.During a follow up inspection of the kitchen in House #21 on 4/30/2026 at 3:59 PM , the following items were found to be out of compliance with New York State food safety regulations:The following items were found without proper labeling and/or dating or past their use by date in the refrigerator in the pantry/storage area behind the kitchen in House #21:An unlabeled plastic container with a red liquid, possibly cranberry juice, with no opened or use by date.A plastic bag of mushrooms and a plastic bag of peeled garlic cloves. The bags for these items were tied in a knot. There was no opened or use by date on either bag.During an interview on 4/27/2026 at 10:55 AM, Assistant Director of Dining Services #1 stated the Main Kitchen prepared the dinner meal for the residents in the nursing home and everything in that kitchen had the potential to be served to residents in the nursing home. All open items should have had a visible expiration date on them. In order to label and date items, they used a data mark printer. When an item was opened, they would enter the product into the printer and it would automatically generate a label with the date the item was opened and the use by date for that item. They stated sometimes items were not dated because they were overlooked, and sometimes it was due to laziness. Not all items in the cooler were used every day, and some items had the date to use them by on their packaging but if an item was taken out of its packaging or original box, it needed to be labeled as staff needed to know when they expired. They stated they were going to throw away all the expired items and everything that was not labeled with a use by date because they did not know when the items were opened or when they needed to be used by.During an interview and observation on 04/30/2026 at 4:10 PM, Certified Nurse Aide # 7 stated items should be labeled and dated with dates the items were opened and when the items needed to be discarded by. They could not say when the mushrooms, garlic, and container of red liquid seen in House #21 on 04/30/2026 were placed in the refrigerator or when they should have been used by because there was no label on them with the date they were opened and the date they should be discarded. They stated they were going to throw those items away and they were observed discarding the items in the trash. 10 New York Codes, Rules, and Regulations 415.14(h)		

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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 performing 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)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review conducted during a survey, the facility failed to ensure that each resident had a person-centered individualized care plan developed and implemented according to professional standards of practice for two (2) (Resident #'s 4 and 22) of 17 residents reviewed. Specifically, (a) for Resident #4, their medicated dandruff shampoo was not noted to be required in the resident's Comprehensive Care Plan; and (b) for Resident #22, the Comprehensive Care Plan did not address the resident's difficulty with speaking. Findings Include: The facility's policy and procedure dated 06/27/2023 titled Interdisciplinary Care Conference and Care Planning documented that at a minimum the baseline care plan will include healthcare information necessary to properly care for each resident immediately upon their admission and address resident-specific health and safety concerns. The plan will include initial goals, physician orders, medications, dietary orders, therapy orders, social services, and any applicable recommendations. The entire interdisciplinary team will participate in the development and implementation of each resident's care plan, working together contributing their knowledge and skill set in an effort to provide the greatest benefit to the resident. All resident care plans should reflect the resident's cultural preferences, values and practices. Resident #4 Resident #4 was admitted to the facility with the diagnoses of atherosclerotic heart disease (a condition where plaque built up inside the heart arteries causing them to harden and narrow), adjustment disorder with depressed mood (a short-term stress-related mental health condition characterized by an intense, emotional reaction to a significant life change or stressor), and need for assistance with personal care (need for someone to assist with activities of daily living). The Minimum Data Set (an assessment tool) dated 04/03/2026, documented Resident #4 was usually understood, usually understood others, and was minimally cognitively impaired. A physician order dated 3/30/2026 documented that the resident was to have Sebex Shampoo 2-2% (Salicylic Acid-Sulfur), apply to scalp topically in the morning every Monday, Friday for dry scalp - apply on shower days. The Kaiser Permanente Website (healthy.kaiserpermanente.org) documented that Sebex 2-2% shampoo was used to treat dandruff and other scalp conditions (such as itching, scaling, flaking). There was no documented evidence that there was any care plan area addressing Resident #4's need for Sebex shampoo or related condition of having dandruff. During an observation on 04/27/2026 at 12:30 PM, Resident #4 was noted to have flaky dandruff appearing skin on their head. During an interview on 4/30/2026, Registered Nurse #1 stated they tried to make sure that care plans were correlated to the resident's medications as best they could. Registered Nurse #1 stated that Resident #4's need for dandruff shampoo should be in the care plan. Resident #22 Resident #22 was admitted to the facility with the diagnoses of hemiplegia and hemiparesis following cerebral infarction (mild weakness to near or total paralysis after having a stroke), dysarthria (a motor speech disorder caused by brain damage that makes it difficult to control the muscles used for speaking), and anarthria (a severe motor speech disorder characterized by the complete loss of the ability to produce articulate speech, resulting from brain injuries or neurological disorders that paralyze speech muscles). The Minimum Data Set, dated [DATE], documented Resident #22 was able to be understood, understood others, and was minimally cognitively impaired. During an interview on 04/27/2026 at 10 AM, Resident #22 was noted to be limited with verbal responses and made more hand gestures for answers instead of words. In response to some questions during the interview process, Resident #22 was noted to not answer at all and just stared at the surveyor. There was no documented evidence that Resident #22's difficulty in verbally responding to questions was included in the Comprehensive Care Plan. During an interview on 05/01/2026 at 1:25 PM, Director of Nursing #1 stated when a resident was admitted to the facility, they go through their diagnoses and problems and put that information into a care plan. All disciplines have a portion of the care plan they were (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Eddy Village Green at Beverwyck		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	responsible for, and care plans were updated if there was a new diagnosis, change in condition, or hospitalization. During an interview on 05/01/2026 at 2:48 PM, Administrator #1 stated if a resident had needs that were care planned for, the care plan should be followed, and the intervention should be done. The care plans should include areas to address issues the residents had and be updated based on changes with the resident. 10 New York Code of Rules and Regulations 483.21 (b) (1)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews conducted during a survey, the facility failed to ensure that it maintained acceptable parameters of nutritional status, provided nutrition care and services to each resident consistent with the resident's comprehensive assessment, recognized, evaluated, and addressed the needs of every resident for three (3) (Resident #s 12, 20, and 22) of three (3) residents reviewed for nutrition/hydration status maintenance. Specifically, Residents #s 12, 20, and 22 had significant weight changes that were not assessed timely. Findings include: Facility policy titled, Clinical Nutrition Services, dated 05/1995 and last revised 01/2024, documented that the registered dietitian or designee would complete a nutrition evaluation within 72 hours of admission. The dietitian would complete a comprehensive nutrition assessment according to the admission date and Minimum Data Set schedule. The dietitian would monitor regularly to ensure residents maintained acceptable parameters of nutritional status. Residents were offered a therapeutic diet when it had been determined that there was a benefit. The procedure documented was the dietitian or designee would complete the comprehensive nutritional assessments within seven (7) days or per community schedule. Documentation must be completed in a timely and accurate manner. All documentation must include a signature, including electronic signage of the respective clinical team member. The quarterly assessment would be completed per the Minimum Data Set schedule. Interval evaluations would be completed for the following, but were not limited to: Resident with a confirmed significant change in weight would be evaluated as soon as possible but no longer than (five) 5 days after notification, a care plan would be updated per review of resident's nutritional status and monitoring frequency determined based on significance, etiology, response to interventions and clinical judgement. Residents with insidious weight loss (gradual unintended progressive weight loss over an extended time). Monitor and document as part of monthly weight review process. Residents identified as at risk per the validated malnutrition screening tool, a progress note would be written, and as needed thereafter. Resident #12: Resident #12 was admitted to the facility with diagnoses of Parkinson's Disease without dyskinesia (a disorder of the central nervous system that affects movement, often including tremors, but did not experience involuntary, erratic movements), dysphagia (difficulty swallowing, often caused by nerve damage, muscular issues, or blockages), and stage three (3) chronic kidney disease (moderate kidney damage). The Minimum Data Set (an assessment tool) dated 03/20/2026, documented the resident had intact cognition, made themselves understood, and understood others. A review of Section K (Swallowing/Nutrition Status) of the Minimum Data Set, dated [DATE] documented Resident #12 had a significant weight loss (of either) five (5) percent or more in the last month, or of 10 percent or more in the last six (6) months). It further documented that Resident #12 was not on a physician-prescribed weight-loss regimen. The Comprehensive Care Plan, initiated 09/17/2025, documented the resident was at nutritional risk and goal, initiated 12/10/2025, included resident would maintain a plus or minus three (3) percent current body weight for 90 days. Interventions included weighing the resident monthly and providing ice cream once (1) daily with dinner as a supplement. Review of the electronic health record revealed significant weight loss for Resident #12 when weighed on 01/02/2026, 02/01/2026, 03/01/2026, and 04/02/2026. There were generated warnings related to significant weight loss. There was no documented evidence that Resident #12's weight loss was assessed when known on 01/02/2026, 02/01/2026, 03/01/2026, until 03/13/2026 when a routine Mini Nutritional Assessment and Nutrition Quarterly Review was completed. Nutrition Quarterly Review dated 03/13/2026 documented a three point seven (3.7) percent loss over the last 30 days, an eight point five (8.5) percent loss over the last 90 days, and a 13 percent loss over the last 180 days. Weight loss continues. (Supplement) plus previously ordered but discontinued due to loose stools and Resident #12 was not interested in taking any supplements. (Supplement) Clear daily now ordered, (Supplement) ice cream provided daily. No changes to plan of (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care at this time and will continue to monitor. Resident #20 Resident #20 was admitted to the facility with the diagnoses of Alzheimer's disease with late onset (a progressive degenerative neurological disease affecting memory), paroxysmal atrial fibrillation (a type of irregular heart rhythm where the upper chambers of the heart beat chaotically and out of sync with the lower chambers), and pharyngeal phase of dysphagia (a swallowing disorder where food or liquid was difficult to move from the throat to the esophagus). The Minimum Data Set, dated [DATE], documented Resident #20 was sometimes able to understand others, was usually understood, and was completely cognitively compromised. A review of Section K (Swallowing/Nutrition Status) of the Minimum Data Set, dated [DATE] documented Resident #20 had no or unknown weight loss (of either) five (5) percent or more in the last month or loss of 10 percent or more in the last six (6) months). The Comprehensive Care Plan, initiated 02/22/2024, documented the resident was at nutritional risk and goal, revised 03/06/2024, included the resident would maintain a plus or minus three (3) percent current body weight for 90 days. Interventions included weighing the resident monthly, initiated 02/22/2024, and to provide a daily supplement on 10/15/2025. Review of Weights and Vitals Summary in Resident #20's electronic health record revealed the following: On 11/01/2025, Resident #20 experienced a four point seven (4.7) percent weight loss. On 11/02/2025, a reweight of the resident confirmed this weight loss. There was no documented evidence that the medical practitioners assessed Resident #20 until a Nutrition Assessment, Mini Nutritional Assessment, and Medical Director/ Nurse Practitioner Weight Alert completed on 01/02/2026. Document titled Nutrition assessment dated [DATE] noted a weight loss trend for the last six (6) months. The resident was receiving a supplement once (1) a day. No changes to plan of care at the time and the resident would continue to be monitored. Review of Weights and Vitals Summary in Resident #20's electronic health record revealed the following: On 04/03/2026, the resident demonstrated a seven point five (7.5) percent weight loss from their weight on 01/02/2026. A warning was generated. On 04/04/2026, a reweight was obtained and confirmed this weight loss. There was no documented evidence that the medical practitioners assessed Resident #20 for the one (1) month significant weight loss on 04/03/2026 through 4/29/2026. On 04/30/2026, it was documented in the Resident's electronic health record the resident's weight loss continued and the resident lost eight point two (8.2) pounds from 03/01/2026 to 04/03/2026. The resident continued on a supplement once (1) a day. Would recommend increasing the supplement t twice daily for weight maintenance. Resident #22: Resident #22 was admitted to the facility with diagnoses of cerebral infarction (the death of brain tissue caused by an interruption of blood flow to the brain), dysphagia (difficulty swallowing, often caused by nerve damage, muscular issues, or blockages), and depression (mood disorder that causes a persistent feeling of sadness and loss of interest). The Minimum Data Set, dated [DATE] documented the resident made themselves understood and understood others. A review of Section K (Swallowing/Nutrition Status) of the Minimum Data Set, dated [DATE] documented Resident #22 had no or unknown loss of five (5) percent or more in the last month or loss of 10 percent or more in the last six (6) months. The Comprehensive Care Plan, initiated 10/15/2025, documented the resident was at nutritional risk. Review of Weights and Vitals Summary revealed Resident #22 exhibited a one (1) month significant weight loss of eight-point four (8.4) percent. Nutrition Quarterly Review dated 04/03/2026 documented the resident was at risk for unintended weight loss due to pain. And that there were no nutrition concerns. There was no documented evidence that the facility assessed Resident #22's significant weight loss until the routine Nutrition Quarterly Review on 04/03/2026. During an interview on 05/01/2026 at 11:07 AM, Certified Nurse Aide #4 stated they would immediately reweigh a resident if they noted that there was a five (5) pound weight change and then speak to the Registered Nurse on duty. During an interview on 5/01/2026 at 12:08 PM, Registered Nurse #1 stated that the facility policy was to obtain monthly weights for the residents that had an order for it, and if there was more than a five (5) pound weight change, the staff would obtain a reweight. They met with the Registered Dietitian on a weekly basis and asked if they wanted more frequent weights ordered. Registered Nurse #1 stated that reweights (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were sometimes hard to get. During an interview on 04/30/2026 at 11:32 AM, Registered Dietitian #1 stated that if there was a one (1) month significant weight change, the Registered Dietitian or the staff member who was adding the weight into the resident's chart would request a re-weight verbally or in an email. They were unable to provide a specific timeframe for when the re-weight would be needed. They further stated that if there was a one (1) or six (6) month significant weight change, the Registered Dietitian would fill out the Weight Alert in the electronic health record. They further stated that the Nurse Manager and Nurse Practitioner or Medical Doctor would sign off that they were aware of the significant weight change. The significant weight change would be documented in a quarterly or annual assessment. If the significant weight change occurred outside of the quarterly or annual timeframe, the Registered Dietitian would complete a progress note for one (1) and six (6) month significant weight changes. If new interventions were added, the Registered Dietitian would update them in the resident's care plan. If a resident continued to lose weight after a significant weight loss, the interdisciplinary team would hold a care conference with the family and discuss findings. During an interview on 05/01/2026 at 1:30 PM, Director of Nursing #1 stated the Physician was at the facility every Tuesday and would discuss significant weight changes. The Registered Dietitian was to complete the nutrition assessments on admission, quarterly, and with significant changes. During an interview on 05/01/2026 at 1:35 PM, Medical Director #1 stated that it was their expectation that the staff would notify them of residents who had significant weight changes. They further stated if a resident had multiple significant weight change alerts, they would be alerted electronically. 10 New York Code of Rules and Regulations 415.12(i)(1)		