STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335148	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Willows at Ramapo Rehab and Nursing Center	30 Cragmere Road Suffern, NY 10901

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335148	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Willows at Ramapo Rehab and Nursing Center	30 Cragmere Road Suffern, NY 10901

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review completed during a complaint investigation (NY00374056) the facility did not maintain infection prevention and control practices in accordance with guidelines for enhanced barrier precautions for one (Resident #2) of three residents reviewed for infection control practices. Specifically, Resident #2 was on enhanced barrier precautions, as indicated by signage posted on the wall outside of their room. On three separate occasions, staff provided hands-on care without wearing gowns. Record review:The facility policy titled Enhanced Barrier Precautions, dated 1/28/25 documented that enhanced barrier precautions are utilized to reduce the transmission of multi-drug-resistant organisms to residents. The policy listed examples of high contact resident care activities requiring gown and glove use one of which was device care or use, as well as dressing a resident.Resident #2's quarterly review minimum data set assessment dated [DATE] documented active diagnoses of sepsis, other chronic osteomyelitis, and gastrostomy malfunction. It indicated that the resident had a feeding tube. It further documented that upon admission Resident #2 had a stage 2 unhealed pressure ulcer, and two stage 3 pressure ulcers.Resident #2's care plan dated 3/31/25 for pressure ulcer development to left heel related to disease process, history of ulcers, and immobility. The goal documented was the residents' pressure ulcer will show signs of healing and remain free from infection. One of the interventions is Enhanced Barrier Precautions.Resident #2 had a medical order for Enhanced Barrier Precaution dated 6/16/25.Observations:On 7/23/25 at 9:42am observed Respiratory Therapist #4 at bed side of Resident #2, they were wearing gloves, but no gown and Resident #2 was dressed only in a brief and noted to be diaphoretic, their head neck and chest were damp. Observed Respiratory Therapist #4 lean over the severely contracted Resident #2 as they were adjusting mask and resident's head as well as moving resident's arms so that they could auscultate lung sounds with a stethoscope. Respiratory Therapist #4 also used a pulse oxygen meter which required movement of resident's arm and hand to place the meter on the resident's finger.On 7/23/25 at 9:45am observed Registered Nurse Manager #5 takeoff gown and proceed to exit Resident #2's room, but they stopped and returned to bedside. At 9:50am observed Registered Nurse Manager #5 at the bedside of Resident #2 assisting Licensed Practical Nurse #6 change the resident's damp gown, Registered Nurse Manager #5 had not put a gown back on and was wearing only gloves when providing this bed side assistance.On 7/23/25 at 10:03am observed Respiratory Therapist #4 at the bedside of Resident #2 changing the equipment to a BiPap mask and machine, Resident #2 was now wearing a hospital gown, and Respiratory Therapist #4 had on gloves but no gown. At 10:05 am Respiratory Therapist #4 left the bed side of Resident #2 and returned at 10:07am in a gown and continued to set up the Bipap.Interviews:On 7/23/25 at 10:21am at the unit nurse's station in an interview with Registered Nurse Manager #5, they stated they were not aware that Respiratory Therapist #4 was not wearing a gown, and they were not sure they needed to wear one, they would have to look into that. They stated that if they saw staff providing care to Resident #2 without a gown on, they would tell the staff member they had to wear a gown.On 7/23/25 at 11:20am in an interview with Licensed Practical Nurse #6 they stated that Respiratory Therapist #4 must have been in a rush, because they usually wear a gown. Licensed Practical Nurse #6 stated that they should have said something when they noticed Respiratory Therapist #4 without the gown. Licensed Practical Nurse #6 stated that Registered Nurse Manager #5 had taken off their gown to leave the room and retrieve a blood pressure machine and when Registered Nurse Manager #5 returned to the bedside to assist them they had forgotten to put a new gown on. Licensed Practical Nurse #6 stated they know they have to say something when someone is not wearing gown. Licensed Practical Nurse #6 added that the staff is aware - there is a sign at the door.On 7/23/25 at 11:45am in an interview with Respiratory Therapist #4 they stated they are new here, and that at their prior facility the enhanced barrier precaution signs were on the door not on the wall. Respiratory Therapist #4 stated they had never seen Resident #2 prior to that day. Respiratory Therapist #4 stated they were in a rush and didn't see the sign, but did notice it after the fact. Respiratory Therapist #4 stated they didn't notice that Resident #2 was not wearing a top, but they did notice resident was diaphoretic. Respiratory Therapist #4 also stated they didn't notice that other staff that were in the room assisting them were wearing a gown. Respiratory Therapist #4 further stated they did not think they needed to wear a gown if they were only listening to breath sounds. On 7/23/25 at 12:13pm in an interview with the Director of Nursing they stated that the staff need to wear gowns when proving care for residents on enhanced barrier precautions. Director