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	10/24/2025

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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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(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 - Actual harm Residents Affected - Few	Based on record review, and interviews conducted during the abbreviated Survey #2637567, the facility failed to ensure residents receive treatment and care in accordance with professional standards of practice, and the comprehensive person-centered care plan for one (1) of three (3) residents (Resident #1) reviewed for neglect. Specifically, Certified Nurse Aide #1 did not provide Resident #1 with staff assistance for meeting their activities of daily living needs during the evening shift on 10/06/2025, despite documenting such care was given. Subsequently, Resident #1 was last seen on 10/06/2025 at 9:12 PM in their room sitting fully clothed in their wheelchair and at 11:51 PM, Resident #1 was found in their room lying face down on the floor between the bed and wheelchair, with their head under the bed and their oxygen nasal cannula dislodged. Resident #1 was short of breath, non-verbal and had lacerations (cuts) on their forehead and neck. Resident #1 was pronounced deceased at 12:20 AM at the facility. This resulted in actual harm to Resident #1 that was not Immediate Jeopardy.The findings include: The undated facility policy and procedure titled Supporting Activities of Daily Living documented: Residents are provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living. Residents who are unable to carry out activities of daily living independently receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. Resident #1 was admitted to the facility with diagnoses including but not limited to pneumonia (lung infection), coronary artery disease (narrow coronary arteries), and heart failure (weak heart muscle). The 09/27/2025 care plan titled Cognitive Function/Dementia documented keep the resident's routine consistent and try to provide consistent caregivers as much as possible to decrease confusion. The 09/27/2025 care plan titled Oxygen Therapy documented change resident position every two (2) hours to facilitate lung secretion/movement/drainage. The 09/27/2025 care plan titled Mixed Bladder Incontinence documented change brief every three (3)-four (4) hours and as needed. The 09/27/2025 care plan titled Bowel Incontinence documented check every two (2) hours and assist with toileting as needed. The 09/27/2025 care plan titled Stage Two (2) Pressure Ulcer on the Sacrum documented monitoring/reminding/assistance to turn/position at least every two (2) hours, more often as needed or requested. The 10/01/2025 five (5)-day admission Minimum Data Set (a resident assessment tool) documented Resident #1 had severe cognitive impairment, was dependent for toileting, transfers, upper and lower body dressing and received substantial to maximal assist for bed mobility, received oxygen, and was admitted with one (1) stage two (2) pressure ulcer. Review of facility video surveillance revealed on 10/06/2025 at 3:40 PM, Resident #1 was wheeled into their room by Designated Representative #2. At 4:06 PM, Certified Nurse Aide #1 entered Resident #1's room and exited the room at 4:06 PM carrying a food tray in their hand. At 4:12 PM Licensed Practical Nurse #3 entered and exited Resident #1's room. At 5:12 PM, Certified Nurse Aide #2 entered Resident #1's room carrying a food tray and exited the room. At 5:46 PM, Certified Nurse Aide #2 entered Resident #1's room and exited carrying a food tray. At 6:58 PM, Licensed Practical Nurse #3 entered Resident #1's room carrying medication and exited at 7:02 PM. At 7:21 PM, Certified Nurse Aide #2 entered Resident #1's room and exited the room at 7:22 PM. At 9:09 PM, Licensed Practical Nurse #3 entered Resident #1's room carrying medication and exited the room at 9:12 PM. The October 2025 Certified Nurse Aide Accountability Record dated 10/06/2025 revealed Certified Nurse Aide #1 documented at 10:34 PM, they provided Resident #1 with one (1) staff assistance with upper and lower body dressing, two (2) staff assistance with chair to bed transfer via mechanical lift, turning and repositioning, and at 10:35 PM, two (2) staff assistance with tub/shower transfer via mechanical lift, supervision or touching assistance with eating, and one (1) staff assistance with toileting hygiene. Review of the facility video surveillance revealed that on 10/06/2025, no staff entered Resident #1's room between 9:12 PM and 11:51 PM. Review of the facility video surveillance revealed that on 10/06/2025 at 11:51 PM, Certified Nurse Aide #3 entered and exited Resident #1's room. At 11:52 PM, Certified Nurse Aide #3 returned to the room with Licensed Practical Nurse #2. At 11:56 PM, Registered Nurse Supervisor #1 arrived on the unit and entered Resident #1's room. On 10/07/2025 at 12:16 AM, paramedics arrived on the unit. Licensed Practical Nurse #2's nursing progress note dated 10/07/2025 documented at 11:50 PM, Certified Nurse Aide #3 called them to Resident #1's room. They observed Resident #1 lying face down on the floor between the bed and wheelchair. The upper part of the body was under the bed, and the legs were sprawled out behind the resident facing the wheelchair and the right leg was folded in. Resident #1 was not verbally responsive but was breathing. Registered Nurse Supervisor #1 was immediately called. When Registered Nurse Supervisor

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview during abbreviated survey #2637567, the facility did not ensure accurate documentation of medical records in accordance with accepted professional standard and practice were maintained for one (1) (Resident #1) of three (3) residents reviewed for activity of daily living care. Specifically, Certified Nurse Aide #1 documented in the electronic medical record activity of daily living cares on [DATE] that had not been provided. Additionally, although Resident #1 expired on [DATE] at 12:20 AM and their remains were removed from the facility at approximately 3:00 AM, Licensed Practical Nurse #10 documented hourly rounding was completed for Resident #1 on [DATE] from 11:45 PM-6:45 AM.The findings included:Resident #1 was admitted to facility with diagnoses including but not limited to Pneumonia, Coronary Artery Disease, and Heart Failure.The [DATE] Five-day admission Minimum Data Set (MDS) documented Resident #1 had severe cognitive impairment, was dependent for toileting, transfers, and upper and lower body dressing and received substantial to maximal assist for bed mobility. It further documented Resident #1 was on oxygen. Resident #1 was admitted with one (1) stage two (2) pressure ulcer and had a foot infection.Review of the [DATE] comprehensive care plan titled Assistance with Activities of Daily Living revealed the resident was dependent with personal care and toileting hygiene with two (2) staff assistance, chair to bed transfer with two (2) staff assistance via Mechanical Lift.The [DATE] evening Assignment Sheet revealed Certified Nurse Aide #1 was assigned to assignment #2.The [DATE] Certified Nurse Aide Accountability Record documented Resident #1 received care from Certified Nurse Aide #1 on [DATE] at 10:34 PM for bed transfer with mechanical lift, turning and repositioning and at 10:35 PM toileting hygieneThe [DATE] Hourly Rounding Sheet revealed Licensed Practical Nurse #10 documented hourly rounding was completed for Resident #1 on [DATE] from 11:45 PM-6:45 AM. Resident #1 expired on [DATE] at 12:20 AM and their remains were removed from the facility at approximately 3:00 AM.During an interview on [DATE] at 11:37 AM, Certified Nurse Aide #1 stated Resident #1's name was not on the assignment sheet on [DATE]. Certified Nurse Aide #1 stated they did not provide care for Resident #1 on [DATE]. They further stated they did not document cares provided for Resident #1 on [DATE] and stated the documentation was entered by someone else. During an interview on [DATE] at 12:43 PM, the Director of Nursing stated certified nurse aide documentation could only be completed by the certified nurse aide using their username and password which they created. They further stated they did not have access to any of the certified nurse aide passwords and certified nurse aides were instructed not to share their passwords. During an interview and observation on [DATE] at 12:02 PM, Certified Nurse Aide #11 stated they were required to enter their username and password to access the electronic medical record software. They stated no other staff member could enter documentation under their name unless they had their password. They stated they never share passwords. Certified Nurse Aide #11 was observed logging into the electronic medical record. Certified Nurse Aide #11 had to enter their username and password in order to document in the system. During an interview on [DATE] at 11:40 AM, Licensed Practical Nurse #10 stated they did not have time to start their documentation on the [DATE] Hourly Rounding Sheet early in the shift due to the incident and police presence. Licensed Practical Nurse #10 stated they started documenting at approximately 2:30 AM to 3:00 AM and should have removed Resident #1's name from the Hourly Rounding Sheet after they expired. During an interview on [DATE] at 12:20 PM, the Director of Nursing stated Resident #1 was removed from the unit by the Medical Examiner at approximately 3:00 AM on [DATE]. The Director of Nursing stated they are unaware why Licensed Practical Nurse #10 documented hourly rounding after Resident #1 was removed from the unit. The Director of Nursing stated Licensed Practical Nurse #10 should have drawn a line through the boxes for times after Resident #1 left the unit. 10 NYCRR 415.22 (a) (1-4)