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	03/13/2026

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 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. Based on observation, interview and record review conducted during the recertification survey from 03/08/2026 to 03/13/2026, the facility did not ensure action as a fiduciary (trustee) of the resident's funds and hold, safeguard, manage, and account for the residents' personal funds deposited with the facility for one (1) (Resident #29) of two (2) residents reviewed for personal funds. Specifically, the facility restricted Resident #29 to receiving money on two (2) days a week and in an amount lower than the resident wanted.The findings are:Resident #29's diagnoses included surgical amputation of the left leg below the knee and partial right foot, congestive heart failure, and diabetes.The 01/14/2026 quarterly Minimum Data Set (a resident assessment tool) documented Resident #29 had intact cognition.The facility policy, Resident Funds, last approved on 10/02/2025, documents that residents have access to their personal funds 24 hours a day, seven (7) days a week.A 11/04/2025 memorandum from the resident's family member documented they would have no problem if the resident requested $5 or $10 a day, but not every day, and would not approve multiple withdrawals in one day.During an interview on 03/09/2026 at 10:25 a.m., Resident #29 stated that their money was only available on Tuesdays and Fridays. During an interview on 3/11/2026 at 12:25 p.m., Business Office Manager #9 stated personal funds were normally available when a receptionist was at the desk during the day and the nursing supervisor could access funds for the residents at night. The quarterly statements were given to the residents or mailed to the families. The facility limited residents to remove $50 a day. Larger amounts required advance notice to the facility to ensure the funds would be available.During an interview on 3/11/2026 at 12:41 p.m., Receptionist #10 stated when a resident wanted money, they confirmed that the resident had an account and had available money. Residents were limited to $50 a day except for Resident #29. Resident #29 was limited to receiving money on Tuesdays and Fridays at $10 a day. Resident #29 had requested money on Mondays and was refused. The resident's family had requested a limit on how much money the resident could receive each day and the number of days in a week available.During a follow-up interview on 03/11/2026 at 12:48 p.m., Business Office Manager #9 stated Resident #29 was withdrawing money every day and the family wanted a limit on how much money the resident could remove weekly. Business Office Manager #9 stated the resident was upset at first but agreed to the plan. Business Office Manager #9 restricted Resident #29 to withdraw $10 twice a week and sometimes increased it to $15.A record review of Resident #29 personal funds account on 03/11/2026 at 01:03 p.m., documented the resident had a balance of $827.52 on 10/01/2025 and $1089.65 as of 03/03/2026. The facility personal fund receipts and statements documented that the resident had withdrawn $10 or $15 dollars at a time from 10/05/2025 to 03/12/2026.During an interview on 03/11/2026 at 3:30 p.m., Resident #29 stated they did not remember if anyone talked to them about how much money they were allowed to take out. Taking money out on Tuesdays and Fridays worked ok for them, but $25 more a week would be better. They liked to buy food and sodas from the vending machines. They tried to make the money last and sometimes it did not work out. When they ran out of money, it made them not want to be there. It did not make them happy when they could not get money out. They had an allowance when they were a kid, and it made them feel like that again. They had been turned away on other days than Tuesday and Fridays when they wanted to withdraw money.During an interview on 03/11/2026 at (continued on next page)

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

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4:15 p.m., Social Worker #1 stated the resident's family member asked by phone call that the resident be restricted on the amount of money to be withdrawn. Social Worker #1 stated that they and Business Office Manager #9 met with the resident to discuss limiting the money taken out each week and the resident agreed to the restriction. Social Worker #1stated they did not document any information about the agreement, when or what the family member requested in the phone calls to the social worker, or the date of the meeting with the resident. During an interview on 03/13/2026 at 10:28 a.m., the Administrator stated no one was restricted in the amount of money they could withdraw each week. The Administrator was not aware of any restriction on Resident #29 ability to withdraw money from the personal funds account.A record review of the resident's electronic health record on 03/13/2026 at 11:00 a.m., documented the resident's family member was listed as the emergency contact and not as power of attorney. 10 NYCRR 415.3(g)(1)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews during the recertification survey, the facility did not ensure the residents' right to a safe, clean, comfortable, and homelike environment for two (2) of eight (8) residents (Resident #126 and Resident #170) reviewed for the environment. Specifically, 1) Resident #126 was observed sitting in a wheelchair that was visibly soiled on the frame, cushion, and protective gauze; 2) Resident #170 was observed sitting in a wheelchair that was visibly soiled on the frame, body, and back of wheelchair. The findings included:The facility policy Wheelchair Cleaning Process, dated 10/03/2025, documented that all resident wheelchairs, cushions, and adaptive equipment are routinely cleaned in accordance with the Centers for Disease Control infection control guidelines to maintain a clean and sanitary environment and to prevent the transmission of infectious agents. Any equipment that is soiled will be added to the daily cleaning schedule. 1) Resident #126 had diagnoses that included dementia, dysphagia (difficulty swallowing), and muscle weakness.The Quarterly Minimum Data Set, dated [DATE] documented the resident had severely impaired cognition, was dependent on staff assistance for transfers, and used a manual wheelchair.During an observation on 03/08/2026 at 12:46PM, Resident #126 was sitting in a wheelchair that had dry dirt caked on the frame and cushion. During an observation on 03/10/2026 at 1:11 PM, Resident #126 was sitting in a wheelchair. There was protective white gauze wrapped on the wheelchair where the leg rests attach bilaterally, it was visibly soiled and had a light brown color. 2) Resident #170 had diagnoses that included unspecified psychosis, dysphagia (difficulty swallowing), and cerebral ischemia (restricted blood flow to the brain).The Quarterly Minimum Data Set, dated [DATE] documented the resident had severely impaired cognition, required moderate assistance from staff for transfers, and used a manual wheelchair.During an observation on 03/08/2026 at 11:50 AM, Resident #170 was sitting in a wheelchair that had a white dried substance on the right wheel spokes and the right side of the wheelchair up to the back rest. The right corner of the wheelchair cushion was visibly soiled with a stain and there was a dusty grime on the wheelchair frame.During an interview on 03/11/2026 at 2:16 PM, Registered Nurse Unit Manager #4 stated wheelchairs were cleaned according to a schedule which housekeeping followed. If there was a wheelchair that was very soiled, they would let housekeeping know so they could clean the wheelchair. During an interview on 03/11/2026 at 2:31 PM, the Assistant Director of Housekeeping stated they tried to follow a wheelchair cleaning schedule, but it could be difficult to follow and was inconsistent. Wheelchairs were scheduled daily on the evening shift, but they did not track and confirm which wheelchairs were completed. The Assistant Director of Housekeeping stated that sometimes chairs that were scheduled were not available, but they did not track that either. They took wheelchairs and clean them as needed when they noticed they were soiled. Staff should have reported wheelchairs that needed to be cleaned to housekeeping. 10NYCRR 415.5(h)(2)

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews during the recertification survey, the facility did not ensure that residents unable to carry out activities of daily living received the necessary assistance with eating for one (1) of six (6) residents (Resident #128) reviewed for nutrition and one (1) of 19 residents (Resident #140) reviewed for dining. Specifically, 1) Resident #128, who had significant weight loss and required maximal assistance with eating was observed receiving only set up assistance during meals; 2) Resident #140, who had a history of weight loss and required moderate assistance with eating was observed receiving mostly only set up assistance during meals. The findings included:The Facility Activities of Daily Living Policy last reviewed 10/03/2025 documented that appropriate care and services are provided for residents who are unable to carry out ADLs independently, with the consent of the resident, and in accordance with the plan of care, including appropriate support and assistance with tasks that include dining (eating, including meals and snacks).1)Resident #128 had diagnoses that included multiple sclerosis (disabling disease of the nervous system), dysphagia (difficulty swallowing), and dementia. The Significant Change Minimum Data Set, dated [DATE] documented severely impaired cognition, maximal assistance required from staff for eating, and significant weight loss in the last six (6) months. The Resident requires assistance with activities of daily living care plan, last revised 12/25/25, documented interventions that included substantial/maximal assistance with eating. The weight record for Resident #128 documented a weight of 161 pounds in October 2025 and a weight of 135 pounds in March 2026, a 16% weight loss.The current Certified Nurse Aide Kardex documented maximal assistance with eating. During an observation on 03/08/2026 at 12:40 PM, Resident #128 was in the unit dining room for lunch picking at their meal. Resident #128 struggled to drink water from the plastic cup provided. No assistance from staff with eating was observed.During an observation on 03/09/2026 at 12:49 PM, Resident #128 was in the unit dining room for lunch and just ate half of the sandwich on their plate. Soup and another cup with fluids remained covered with plastic tops. No assistance from staff with eating was observed.During an observation on 03/10/2026 at 12:51 PM, Resident #128 was in the unit dining room for lunch. They only consumed the turkey from their sandwich. No assistance was observed from staff except questioning if they wanted to eat more when removing the tray. 2)Resident #140 had diagnoses that included dementia, severe protein calorie malnutrition, and dysphasia (impaired speech).The Quarterly Minimum Data Set, dated [DATE] documented severely impaired cognition, moderate assistance required from staff with eating, and no significant weight loss in the last 6 (six) months. The Resident requires assistance with activities of daily living care plan, last revised 09/14/2023, documented interventions that included moderate assistance with eating. The weight record for Resident #140 documented a weight of 124 pounds in October 2025 and a weight of 120 pounds in March of 2026, a 3.2% weight loss. The current Certified Nurse Aide Kardex documented moderate assistance with eating.During an observation on 03/08/2026 at 12:42 PM, Resident #140 was in the unit dining room for lunch with their meal tray in front of them. Resident #140 played with wrappers and a spoon; no intake was observed. At 12:53 PM Resident #140 continued to play with their utensils and food. They put a plastic top on the hot food and pushed it down. No assistance or interventions from staff were observed. At 1:07 PM staff removed the plastic cover that Resident #140 pushed into the food, assisted with a few bites, and then they removed the tray. During an observation on 03/09/2026 at 12:49 PM, Resident #140 was served their meal tray and set up assistance was provided. Resident #140 played with silverware and plastic wrappers, picking at food. They did take a few small bites. They attempted to put the spoon in the applesauce, but a plastic lid was covering it, and they were unable to access it. They were then reorganizing items on their tray. No encouragement or assistance from staff was observed. At 1:01 PM Resident #140's intake remained very poor, with an occasional small bite, and they remained sitting in their wheelchair (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	quietly. At 1:08 PM Resident #140 had eaten a minimal amount, no assistance or encouragement was observed from staff, applesauce and juice remain sealed. At 1:10 PM, trays were being cleared, staff put a straw in the juice for Resident #140, left it for them, and took the meal tray. During an observation on 03/11/2026 from 9:11 AM until 9:34AM, Resident #140 was observed in bed with their breakfast tray still in front of them. No food was eaten, all open and set up, but they were not actively eating or drinking, and no assistance was provided by staff. At 9:24 AM Resident #140 remained in bed, looking at a paper pamphlet, not eating, tray remained untouched. At 9:34 AM Certified Nurse Aide #7 entered the room and asked Resident #140 why they weren't eating and encouraged them to eat. Certified Nurse Aide #7 left the yogurt and supplement drink for the resident, took the tray, and left the room. During an interview on 03/11/2026 at 10:58 AM, Certified Nurse Aide #7 stated breakfast trays were distributed to all the residents on the unit between 7:45AM-8:00AM. They stated that Resident #140 required set up assistance for meals. They stated that Resident #140 ate yogurt and drank a supplement drink today but refused the hot food. They stated Resident #140 had a pretty good appetite and did not require any special assistance with meals. During an interview on 03/12/2026 at 10:40 AM, the Director of Rehabilitation stated Resident #128 required maximal assistance and Resident #140 required moderate assistance with eating. Moderate assistance means the staff perform 50% and the resident performs 50% of the task. Maximal assistance means that the staff perform 75% and the resident performs 25% of the task. They would expect nursing to check the documented level of assistance needed and assist at that level. They would also expect nursing to notify rehabilitation if there was a change in the level of assistance required so they could reassess the resident. During an interview on 03/12/2026 at 11:20 AM, Certified Nurse Aide #8 stated that Resident #128 required set up assistance with eating. Resident #128 did not request or want any help with meals, and their appetite was usually about 50%. They were not aware of any weight loss for Resident #128. They did not usually look at the Kardex to determine the level of assistance residents required with eating. They stated they were familiar with the residents that have been here and relied on shift-to-shift report for any changes. They stated if a resident required moderate or maximal assistance with eating, that meant that they required some assistance from staff. During an interview on 03/12/2026 at 11:45 AM, the Dietician stated they were following both Resident #128 and Resident #140 for weight loss. Resident #128 required maximal assistance and Resident #140 required moderate assistance with eating. They stated those were accurate. Resident #128 needed monitoring and assistance because they often thought they ate better than they did. Resident #140 needed assistance and encouragement with eating. Both Resident #128 and Resident #140 may not eat well if they were not provided with the assistance needed as determined and documented on their care plan.During an interview on 03/13/2026 at 1:31 PM, Registered Nurse Unit Manager #4 stated they were aware of the residents at risk for weight loss and those with weight loss from the alerts in the electronic medical record. Weights were also discussed in morning report when all members of the interdisciplinary team were present. The certified nurse aides should know what level of assistance the residents need from report at change of shift and the Kardex. Registered Nurse Unit Manager #4 stated that they were responsible for ensuring that the residents that need assistance were receiving it. Both Resident #128 and Resident #140 needed monitoring and assistance during meals. 10NYCRR 415.12(a)(3)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews during the recertification survey, the facility did not ensure that the residents' environment remained as free of accident hazards as possible for one (1) of two (2) residents (Resident #72) reviewed for Accidents. Specifically, Resident #72 had a history of falls and multiple safety interventions in place including keeping the environment well lit and clutter free. Floor mats were determined to be a tripping hazard and not included as an intervention for their safety; however, floor mats were observed in the room and staff reported that they were in use. The findings included:The Facility Managing Fall Risk and Prevention policy dated 06/24/2025 documented based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Resident #72 had diagnoses that included dementia, obstructive uropathy (a condition blocking urine flow), and cerebral ischemia (restricted blood flow to the brain).The Fall Risk assessment dated [DATE] documented Resident #72 was high risk for falls. Risk factors included one (1) to two (2) falls in the last six (6) months, antihypertensive use, impaired memory recall, total incontinence, and unable to independently stand.The At risk for/history of falls care plan, dated 02/03/2026, documented a goal that resident will remain free of falls. Interventions included, but not limited to, keeping call bell in reach and reminding resident to use it, keeping the environment well-lit and free of clutter, and non-skid socks when not wearing shoes.The Five-Day Minimum Data Set, dated [DATE] documented severely impaired cognition, maximal assistance from staff for transfers, and falls in the last month and falls in the last two (2) to six (6) months prior to admission and/or re-entry. The Resident has had an actual fall care plan last revised 03/10/2025 documented falls on 12/12/2025, 01/11/2026, 01/31/2026, and 03/09/2026. The goal was resident will resume actual activities without further incident. Interventions dated 12/04/2025 included, but not limited to, continuing interventions on the at-risk care plan, monitor/document/and report any pain, bruises, change in mental status or new onset confusion, sleepiness, inability to maintain posture, or agitation. Interventions dated 12/13/2025 included toileting schedule/floor mats. Interventions dated 01/11/2026 included floor mats to both sides of the bed removed tripping hazard.The current Minimum Data Set Kardex had no documented evidence of floor mat use. During an observation on 03/11/2026 at 9:13 AM, Resident #72 was observed in bed. One floor mat was folded up and leaning against the wall by their bed. During an interview on 03/11/2026 at 2:22 PM, Certified Nurse Aide #8 stated they were familiar with Resident #72 and were assigned to provide them with care today. They stated Resident #72 was dependent on staff assistance for care. They stated Resident #72 has improved since they came to the facility and were able to stand and pivot now with assistance. Resident #72 had a history of falls and had floor mats for safety. Resident #72 will not use the call bell, so they need to check on them frequently. During an observation on 03/12/2026 at 9:05 AM, Resident #72 was observed in bed while staff removed their breakfast tray from the bedside table. Two floor mats were observed in the room folded up against the wall on their side of the room. During an interview on 03/12/2026 at 10:08 AM Certified Nurse Aide #8 stated that the floor mats in the room were for Resident #72, not for their roommate. They stated that they were folded up against the wall right now because housekeeping had just cleaned the floor and had to move them to do so. They stated they were going to provide morning care and get them up now, so they were not put back down. During an interview on 03/12/2026 at 10:59 AM, Registered Nurse Unit Manager #4 stated that Resident #72 had floor mats in their room, but they were discontinued previously. The floor mats should not have been in the room or in use as they were previously determined to be a tripping hazard. They removed the floor mats today.10NYCRR 415.12(h)(1)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility did not ensure care consistent with professional standards of practice, and the comprehensive person-centered care plan was provided for one (1) of two (2) residents (Resident #69) reviewed for Respiratory Care. Specifically, Resident #69 was administered oxygen at a liter flow greater than the current physician's order.The findings included:An undated, untitled facility policy documented guidelines for safe oxygen administration included review the physician's orders or facility protocol for oxygen administration.Resident #69's diagnoses included dysphagia following other cerebrovascular disease, Alzheimer's disease and chronic obstructive pulmonary disease. The quarterly Minimum Data Set, dated [DATE] document Resident #69 had severe cognitive impairment, was short of breath when lying flat and received oxygen therapy. A physician order dated 03/03/2026 documented two (2) liters of oxygen via nasal cannula continuously every shift for chronic obstructive pulmonary disease. A resident care plan titled oxygen therapy related to ineffective gas exchange two (2) liters via nasal cannula continuously updated 03/04/2026 documented interventions including administer medications as per physician order. During observations on 03/08/2026 at 12:10 PM and 3:21 PM and 03/09/25 at 9:42 AM, Resident #69 was sleeping in bed with oxygen being administered via nasal cannula. The oxygen concentrator was observed running at three (3) liters/minute. During an interview and observation on 03/12/2026 at 9:46 AM, Resident #69 was observed sleeping in bed with oxygen being administered via nasal cannula. Licensed Practical Nurse #6 stated Resident #69's oxygen concentrator was administering between three (3) to four (4) liters/minute and the physician ordered administration rate was two (2) liters per minute. They stated they did not check oxygen concentration levels during medication pass earlier in shift and should have. During an interview and observation on 03/12/2026 at 11:54 AM, Assistant Director of Nursing stated physician orders needed be followed for oxygen administration. Upon review of electronic medical record, the Assistant Director of Nursing stated Resident #69's physician order was for oxygen to be delivered at two (2) liters/minute. They stated nursing staff should check the oxygen concentrator liters/minute administration during medication administration and when the resident taken out of bed or moved to a portable unit. They needed to re-adjust the administration levels to the physician prescribed level if necessary. 10NYCRR 415.12 (k)(6)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review conducted during the recertification survey from [DATE] to [DATE], the facility did not ensure a resident received behavioral health services to attain their highest practicable well-being, in accordance with the comprehensive assessment and plan of care. This was evident for one (1) (Resident #9) of one (1) resident reviewed for Behavioral/Emotional Status. Specifically, Resident #9 had a physician order for a psychiatry and psychology consultation after making an inappropriate sexual comment to another resident on [DATE]. Resident #9 was not evaluated by a psychiatrist or psychologist in accordance with the physician order. The findings included:A facility policy titled Behavior Health Services, revised 04/2024 documented the facility will provide and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care.Resident #9 diagnoses included displaced intertrochanteric fracture of left femur, bilateral osteoarthritis of hip and hypertension. The admission Minimum Data Set (a resident assessment tool) dated [DATE] documented Resident #9 was cognitively intact, reported feeling down, depressed, and hopeless several days and had no behaviors, hallucinations, or rejection of cares. A physician order dated [DATE] documented psychology consult and follow up as needed.A resident care plan dated [DATE] documented resident has a potential for a psychosocial well-being problem (actual or potential) related to recent admission. Interventions included consult with pastoral care, social services, and psychological services. A physician order dated [DATE] documented psychiatry consult and follow up as needed.A nursing note dated [DATE] documented It was reported that Resident #9 was overheard saying to another resident having sex with you would be the best thing ever. Resident was redirected. Referred to Social services. Physician notified. Resident will follow up with psychiatry.A resident care plan dated [DATE] documented resident exhibits behavior symptoms such as socially inappropriate (making sexual comments to another resident. Interventions included enhanced monitoring for behaviors, initiate psychiatric evaluation as needed weekly and initiate psychology evaluation as needed.A physician order dated [DATE] documented enhanced monitor every shift for inappropriate behaviors.A nursing note dated [DATE] documented Resident #9 was scheduled for pulmonary appointment and declined to go. When encouraged, Resident #9 became upset and voiced, four of my family died from lung cancer anyway, so why would I go? Necessity of appointment was explained to resident but still declined. Physician notified.A nursing note dated [DATE] documented Resident #9 was speaking with another resident when staff went to explain the nurse needed the other resident. Resident became upset, aggressive and attempted to grab staff to interfere. During a brief interview on [DATE] at 11:41 AM, Resident #9 stated they did not wish to be interviewed. Resident #9 stated too many people around here talking about me and they either like me or don't. Resident #9 stated they had no concerns. During an observation and brief interview on [DATE] at 9:16 AM Resident #9 was observed in their room sitting in wheelchair, completing breakfast. WHen asked how they were feeling, Resident #9 stated good. Don't worry if there was a problem I would be out there letting people know. I advocate for myself. During an observation on [DATE] at 12:34 PM, Resident #9 was in day/dining area engaging with staff/residents appropriately. During an observation on [DATE] at 10:39 AM, Resident #9 was presented in their wheelchair on unit hallway. When asked how they were, Resident #9 responded I am alive and self-propelled to day area. During interviews on [DATE] at 10:42 AM and 12:48 PM, Registered Nurse Unit Manager #5 stated Resident #9 made an inappropriate sexual comment to another resident on [DATE]. They stated they immediately contacted the Social Work Department and physician who requested a psychiatry and psychology consult for Resident #9. They stated since [DATE], Resident #9 also had periods of upset when they were to attend a community (continued on next page)

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	335148	A. Building B. Wing	03/13/2026

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician and when they were separated from sitting next to the resident they had made the sexual comment to on [DATE]. Registered Nurse Unit Manager #5 stated they were unable to locate a psychiatry or psychology consult note in the electronic medical record from [DATE] to present and did not know if the consults had taken place. They stated psychology consults were requested by email from the Assistant Director of Nursing who was no longer with the facility, and they were unaware if they received an email to consult with Resident #9. They stated the psychiatry consultant recently had an emergency and they were not aware if they consulted Resident #9. They stated they were not aware why the psychology consult did not take place and that Resident #9 would be seen today. During an interview on [DATE] at 12:54 PM, the Director of Nursing stated the Consultant Psychiatrist usually services the facility once a week and were not aware when the Consultant Psychiatrist last visited the facility. The Director of Nursing stated they were unaware if Resident #9 was seen by psychiatry or psychology since [DATE] and were unable to locate a psychiatry or psychology consult note for Resident #9 in the electronic medical record. They stated they have reached out to the psychiatry consultant group and will have the consultant psychologist see Resident #9 today. During an interview on [DATE] at 1:32 PM, the Psychology Consultant stated the unit facility staff provide a verbal report of residents with a physician order for a psychology consult during their one to two facility weekly visits. They stated routine visits usually occur within 24-48 hours and crisis residents were seen immediately. They stated they had not been asked to consult with Resident #9 since [DATE] until today and confirmed that their co-worker psychologist, who shares the facility. also had not been requested to consult with Resident #9. 10 NYCRR 415.12(f)

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	03/13/2026

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews during a recertification survey from 3/08/2026 to 3/13/2026, the facility did not ensure that food was stored in accordance with professional standards for food service safety. Specifically, six (6) food items were not properly identified in the kitchen refrigerators, freezers, and food storage areas and one dietary cook was not wearing a beard net while actively preparing food.The findings include:The policy titled Food Receiving and Storage last approved 09/12/2025, documented that refrigerated foods are labeled, dated and monitored.On 3/08/2025 at 11:28 a.m., the initial inspection of the kitchen was conducted with the Dietary Supervisor, and the following were observed:One (1) tray of apple and pineapple cups not labeled with identification in the snack refrigerator.One (1) tray of cottage cheese cups, three (3) apples in cups and two (2) oranges in cups were not labeled with identification in the snack refrigerator.One (1) tray of pudding cups not labeled with identification in the portable tray rack.Three (3) peanut butter cups not labeled with identification in the portable tray rack.One (1) bag of mixed vegetables not in its original container and not labeled with identification in the freezer.Five (5) plates of lettuce not labeled with identification in the freezer.During an observation and interview on 03/08/2026 at 11:35 a.m., Dietary [NAME] #1 was observed leaning over and slicing chicken breasts without wearing a beard net. Dietary [NAME] #1 stated they were aware they had to wear a beard net and would normally wear one but forgot that morning. During an interview on 03/08/2026 at 11:36 a.m., Dietary Supervisor #2 stated food needed to be labeled, dated and all staff were to wear hair and beard nets if needed.10NYCRR 415.14(h)