STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335185	A. Building B. Wing	11/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Manor Nursing & Rehabilitation Center	32 Cedar Lane Ossining, NY 10562

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review, and interviews during an abbreviated survey (2622924), the facility did not ensure a comprehensive care plan was developed and implemented to maintain the resident's highest practicable physical, mental, and psychosocial well-being for one (1) of three (3) residents reviewed for behaviors. Specifically, there was no documented evidence of a behavior care plan for Resident # 1 who had a diagnosis of dementia with other behavioral disturbances and had multiple nursing progress notes as well as staff interviews that revealed that Resident # 1 refused care and had behaviors.A review of the facility's Resident Assessment and Care Planning Policy last revised 01/25/2025 documented it is the policy of the facility to maintain accurate and current comprehensive assessment and person-centered plan of care for each resident.The facility's Activities of Daily Living Policy dated 5/2025 documented it is the policy of the facility that all residents are assisted with their activities of daily living according to each resident's individual plan of care. admission Minimum Data Set (an assessment tool) dated 08/12/2025 documented that the resident had a Brief Interview of Mental Status score of 10; indicating the resident was moderately cognitively intact with no behaviors present. Resident had no impairments to the upper extremities and one side impairment to the lower extremity. Resident uses a wheelchair for locomotion. Requires supervision with eating and maximum assistance with toileting. Moderate assist with bed mobility and maximum assist with transfers. Frequently incontinent of urine and bowel. Resident is on antipsychotic, antianxiety, antidepressants.Review of all care plans indicated there was no documented evidence of a behavior care plan for Resident #1.A review of a respiratory progress note documented by Respiratory Therapist #1 dated 08/06/2025 at 9:21am documented Incentive Spirometer recommended for lung expansion therapy with goals to increase lung volumes, strengthen the lungs and reduce the rate of pneumonia. Resident refused incentive spirometry and stated they are not feeling well.A review of a respiratory progress note documented by Respiratory Therapist #1 dated 08/07/2025 at 8:29pm documented Resident #1 refused Incentive spirometry therapy.A review of a nursing progress note documented by Registered Nurse #2 dated 09/03/2025 at 10:16pm documented Resident #1 is alert and confused. Family member and resident refused shower.A review of a nursing progress note dated 09/08/2025 at 10:21pm documented Resident #1 refused bedpan but after encouragement used it and went to bed.A review of a nursing progress note documented by Licensed Practical Nurse #4 dated 09/26/2025 at 10:30pm documented Resident #1 refused to be showered this morning, writer intervened by encouraging resident and daughter-in-law was also present who also intervened. Bed bath given.A review of a nursing progress note documented by Registered Nurse #3 dated 09/30/2025 at 9:57pm documented that Resident #1 refused care and stated, I will go home tomorrow resident sat in the front of the bed stated, I going to report you if you touch me. Will continue to monitor resident behavior.During an interview with Certified Nurse Aide #3 at 11/3/2025 at 3:05pm they stated Resident #1 was assigned to them when they were moved from the east wing to the north wing. Resident #1 would always cry that they want to go home, and they did refuse the bedpan.During an interview with Certified Nurse Aide #4 on 11/12/2025 at 10:53am they stated they are familiar with Resident #1 because they worked with Resident #1 on the east wing. Certified Nurse Aide #4 stated the resident will always scream when you attempt to provide care to them, and Resident #1 reports to them that they want to go home. Sometimes when you attempt to provide care to Resident #1, they will scream that they are in pain. Certified Nurse Aide #4 stated sometimes Resident #1 did not want to use the bedpan. If a resident refuses care, there is no way for the certified nurse aide to document this in point click care (an electronical medical record); therefore, they report to the nurse directly when a resident refuses care. Certified Nurse Aide #4 stated that Resident #1 had behaviors where they would yell for staff to get out of the room and refusal of cares.During an interview with the Director of Nursing on 11/17/2025 at 10:06am they stated Resident #1 had behaviors where they would be weepy, cry out and refuse cares. In review Resident #1's care plans with Director of Nursing, they stated they will have to further review the care plans.During a follow up telephone interview with the Director of Nursing on 11/17/2025 at 1:48pm they stated they took the time to review the care plans and spoke to Unit Manager #2 about the care plans. Director of Nursing stated that Resident #1 did not have a behavior care plan in place, and Unit Manager #2 was documenting the behaviors in nursing progress notes. Director of Nursing stated they instructed Unit Manager #2 to initiate a behavior care plan for Resident #1, and they can reference to the nursing notes for the behavior care plan. If a resident was refusing care, then that can be a part of the behavior care plan. 415.11(c)(1)

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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. (continued on next page)

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F 0677 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 record review, and interviews during an abbreviated survey (2622924), the facility did not ensure a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 (one) out of 3 (three) residents reviewed for activities of daily living. Specifically, Resident #1 had 2 (two) grievances on file for 08/25/2025 and 09/15/2025 related to care. 1) 08/25/2025 Resident #1's Representative found them in the facility smelling of urine and prior to their arrival a family member was there and reported that staff did not change Resident # 1. 2) On 09/15/2025 Resident #1's Representative found them in the day room requesting to go to the bathroom and Certified Nurse Aide #4 refused to put them on the bedpan and stated the resident is a Hoyer and threw the bedpan. On 08/17/2025 the resident was transferred to the hospital with admitting diagnosis of sepsis. On 08/21/2025 documented discharge diagnosis sepsis, community acquired pneumonia, urinary tract infection, acute kidney injury.The facility's Activities of Daily Living Policy dated 5/2025 documented it is the policy of the facility that all residents are assisted with their activities of daily living according to each resident's individual plan of care. Activities of Daily Living are defined as toileting, bathing, personal hygiene/ dressing and grooming, transfer/bed mobility, ambulation/locomotion and eating.Resident #1 is an [AGE] year-old that was admitted to the facility on [DATE] with diagnosis that include but not limited to dementia with other behavior disturbances, displaced fracture of the greater trochanter of the left femur, and chronic kidney disease. An admission Minimum Data Set, dated [DATE] documented that the resident had a Brief interview for mental status score of 10; indicating the resident's cognition was moderately impaired with no behaviors present. Resident had no impairments to the upper extremities and one side impairment to the lower extremity. Resident used a walker for locomotion. Requires supervision with eating and maximum assistance with toileting. Moderate assist with bed mobility and maximum assist with transfers. Frequently incontinent of urine and bowel. Resident is on antipsychotic, antianxiety, antidepressants, and anticoagulantsReview of an activity of daily living care plan dated 8/21/2025 documented Resident #1 requires assist with activities of daily living function due to current primary medical condition.Review of a Urinary Incontinence Care Plan dated 8/8/2025 documented the resident has bladder incontinence related to confusion, impaired mobility. Potential for urinary tract infection with a goal that the resident's risk for septicemia will be minimized/prevented via prompt recognition and treatment of symptoms of urinary tract infection through the review date initiated on 8/8/2025 interventions initiated on 8/8/2025 documented BRIEF USE: The resident uses (incontinent) disposable briefs to maintain dignity, clean peri-area with each incontinence episode, monitor/document for signs and symptoms of urinary tract infection: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns.Review of a nursing progress note dated 08/16/2025 at 4:05pm documented Resident #1 was sent to the hospital with provider order, due to change in mental status wherein she was unable to answer questions, pain, drop in oxygen saturation, tachycardia, yellowing of skin, and general malaise. Family made aware of transfer. Review of a nursing progress note dated 08/17/2025 at 03:42am documented Resident #1 admitted to the hospital. Admitting diagnosis Sepsis. Provider and Family aware. A hospital Discharge summary dated [DATE] documented discharge diagnosis sepsis, community acquired pneumonia, urinary tract infection, acute kidney injury.Review of a grievance dated 8/25/2025 documented that the family found the resident smelling of urine on 8/24/2025 when they arrived at 5pm. Prior to their arrival another family member was there on 8/24/2025 from 9:30am-12:30pm and reported to the family member coming in that no cares were provided to Resident #1.Certified Nurse Aide documentation for August 2025 Bowel and Bladder Elimination had omissions in documentation for day shift 7-3pm on 08/05/2025,08/07/2025-08/10/2025, 08/12/2025-08/13/2025,08/15/2025, 08/21/2025, 08/23/2025, 08/28/2025 and 08/29/2025. Evening shift 3-11pm had omissions on 08/05/2025,08/12/2025, 08/13/2025, 08/15/2025, 08/16/2025, 08/22/2025, 08/23/2025, 08/25/2025, 08/27/2025 and 08/29/2025. Night shift 11- 7am had omissions in documentation on 08/07/2025, 08/10/2025 and 08/13/2025, 08/15/2025, 08/22/2025, 08/24/2025, and 08/31/2025.Certified Nurse Aide documentation for August 2025 toilet transfers had omissions in documentation for Day shift 7-3pm on 08/12/2025, 08/13/2025, 08/15/2025, 08/21/2025, 08/23/2025, 08/28/2025, and 08/29/2025. Evening shift 3-11pm had omissions on 08/10/2025, 08/12/2025 08/13/2025, 08/15/2025 08/16/2025