STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335231	A. Building B. Wing	07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Excel at Woodbury for Rehab and Nursing, L L C	8533 Jericho Tpke Woodbury, NY 11797

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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	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, record review, and interviews during the Recertification Survey initiated on 7/15/2025 and completed on 7/22/2025, the facility did not ensure that it developed and implemented a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet each resident's medical, nursing, and mental and psychosocial needs for one (Resident #82) of two residents reviewed for Skin Conditions and one (Resident #64) of one resident reviewed for Edema. Specifically, 1) Resident #82 was admitted to the facility with a condition identified by the Physician as possible Melanoma (the most serious form of skin cancer). The location of the skin lesion was not identified in the medical record, and a comprehensive care plan was not created with nursing interventions for monitoring and care; and 2) Resident #64 had a Physician Order for an Ace wrap (a compression or elastic bandage that provides support and compression to an area of the body) to lower legs bilaterally (both) once daily for Lymphedema (tissue swelling caused by accumulation of protein-rich fluid). There was no care plan developed to address Resident #64's use of the Ace wrap and Lymphedema of both the lower extremities. The findings are: The facility's policy titled Comprehensive Care Plans and Resident/Patient Meeting, dated 4/2025, documented within 14 days of the resident's admission, a comprehensive assessment of the resident's needs will be prepared and developed by the interdisciplinary team; the purpose of the assessment is to accurately communicate the resident's capability to perform daily life functions and to identify significant impairment(s) in functional capacity and the plan suggested by the team for improvement/maintenance for each of the resident's primary care issues. Information obtained from the comprehensive assessment and staff interviews enables the facility staff to plan care that focuses on the resident's ability to achieve their highest practicable mode of functioning, which includes but is not limited to the following: Medically defined condition(s) and past medical history. 1) Resident #82 was admitted with diagnoses including Cerebrovascular Accident, Colon Cancer, and Muscle Wasting. The 5/28/2025 admission Minimum Data Set assessment documented a Brief Interview for Mental Status score of 11, indicating the resident had moderate cognitive impairment. There was no documentation of ulcers, wounds, or skin problems. The Nursing admission assessment dated [DATE] documented the resident had a scabbed area at the top of their head. The Physician #1 admission Note dated 5/28/2025 documented possible Melanoma under current diagnoses and in past medical history. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/16/2025 at 9:42 AM, Resident #82 was in their room in a wheelchair. The resident had a dry dressing on top of their head. The resident stated they have many scabs on their head, and they pick at them. The resident stated they had seen a Dermatologist prior to coming to the facility and were diagnosed with skin Cancer. A review of the medical record revealed no Comprehensive Care Plan for the skin lesions, scabs, or possible Melanoma on the resident's head, no order for the dry dressing, and no order for monitoring the skin lesions. During an interview on 7/16/2025 at 10:20 AM, Registered Nurse #2 and Registered Nurse #3 (both unit Managers) stated they did not know who put the dressing on Resident #82's head. They stated there was no current order for the dressing and there was no care plan for the lesions on the resident's head. A physician's order dated 7/16/2025 at 10:44 AM documented to put a dry protective dressing on the right parietal scalp to protect the dry scab for prophylactic measures. A comprehensive care plan was added effective 7/16/2025, titled Skin Integrity-Actual Impairment, Dry Scab on the Scalp. Interventions include monitoring for skin changes and a Dermatology consult. The care plan does not indicate that the scab was possibly a Melanoma; there were multiple scabs on the resident's head, and the resident had a behavior of picking the scabs on their head. During an interview on 7/16/2025 at 1:32 PM, Physician #1 stated they were not sure if the resident had Melanoma, and they were monitoring the resident. Physician #1 stated they could not recall the location of the resident's lesions without reviewing their notes. During a re-interview on 7/16/2025 at 1:37 PM, Registered Nurse #2 stated they were not sure of the location of the possible Melanoma and would have to clarify with the Physician. A nursing progress note dated 7/16/2025 at 1:55 PM, written by Registered Nurse #2, documented they spoke with Physician (#1) and clarified that the possible Melanoma was on the resident's right parietal scalp (located at the top and back of the skull). A dermatology consultation was ordered for further evaluation. During a re-interview on 7/21/2025 at 10:25 AM, Registered Nurse #2 stated the possible Melanoma was being monitored by the nurses daily and by the Certified Nursing Assistants on shower days during skin checks. Registered Nurse #2 further stated that they just added the care plan for Skin Integrity-Actual Impairment, which should indicate possible Melanoma. During a re-interview on 7/21/2025 at 10:52 AM, Physician #1 stated the location of the possible Melanoma was on top of the resident's head, and the nurses should be monitoring the resident's scalp for any changes in the lesions. A review of the medical record revealed no documented evidence before 7/16/2025 that the lesions on top of the resident's head were being monitored. During an interview on 7/21/2025 at 2:00 PM, Licensed Practical Nurse #1 stated on 7/16/2025, the resident requested the nurse to put a dressing on the resident's head because the scab was very itchy. Licensed Practical Nurse #1 stated they placed a dry dressing as per the resident's request and (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	told Registered Nurse #2; however, they did not add a progress note or get an order for the dressing. A physician's order dated 7/21/2025 at 2:01 PM documented to obtain a dermatology consultation for 7/22/2025. During an interview on 7/22/2025 at 9:07 AM, Licensed Practical Nurse/Wound Care Nurse/Assistant Director of Nursing Services #1 stated that a care plan did not have to be put in because there was no definite diagnosis of Melanoma. The staff can not put a care plan for every resident who has a scab. The possible Melanoma did not require any special focus care planning. During an interview on 7/22/2025 at 9:45 AM, the Director of Nursing Services stated the lesion on the resident's head was just a scab when the resident was admitted , so there was no need for a care plan. The possible Melanoma was not an official diagnosis, and skin monitoring is completed during the skin checks; therefore, any special focus care planning was not required. 2) Resident #64 was admitted with diagnoses including Lymphedema, Asthma, and Anemia. The Quarterly Minimum Data Set (MDS) assessment completed on 5/2/2025 documented a Brief Interview of Mental Status (BIMS) score of 15, which indicated that Resident #64 had intact cognition. The Quarterly Minimum Data Set assessment documented an active diagnosis of Lymphedema. A Physician's Order dated 6/29/2025 documented Ace wrap to bilateral(both) lower legs daily for Lymphedema. A review of Resident #64's electronic medical record revealed no care plan indicating individualized goals and interventions for Lymphedema, and for the use of the Ace wrap or the compression stocking on both legs until 7/18/2025. During an observation on 7/15/2025 at 10:41 AM, Resident #64 was in bed and wearing the compression stockings on bilateral lower legs. Resident #64 stated they had Lymphedema and always needed the compression stockings. During an interview on 7/17/2025 at 3:26 PM, Registered Nurse #1, Unit Manager, stated there was no care plan developed to address Resident #64's Lymphedema, and the use of Ace wrap or compression stockings. Registered Nurse #1 further stated a care plan with individual goals and interventions should have been developed to address use of the Ace wrap or compression stocking for Lymphedema. During an interview on 7/17/2025 at 4:08 PM, the Assistant Director of Nursing Services stated a care plan should have been developed to address the resident's skin integrity, Lymphedema, and use of compression stockings. During an interview on 7/18/2025 at 1:20 PM, the Director of Nursing Services stated they expect all care plans to be updated to address the resident's individual needs. 10 NYCRR 415.11(c)(1)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interviews during the Recertification Survey initiated on 7/15/2025 and completed on 7/22/2025, the facility did not ensure that drugs and biologicals were stored in a locked compartment. This was identified for one (Resident #7) of three residents reviewed for Accidents. Specifically, Resident #7 was observed with a tube of Lidocaine (a topical anesthetic that provides temporary pain relief by numbing the applied area) 5 percent ointment on Resident #7's overbed table. Additionally, there was an open storage box on top of Resident #7's overbed table containing two bottles of unlabeled glucose 4-gram tablets (treat low blood sugar). There was no Nursing staff in the vicinity of Resident #7's room. Resident #7 was not assessed to administer their medications. The finding is:The facility's undated policy titled Storage of Medications documented that compartments containing drugs shall be locked when not in use. These include drawers, cabinets, refrigerators, carts, and boxes. Drugs for external use shall be stored separately from regular medications and shall be labeled for external use only on the medication container. No discontinued, outdated, or deteriorated drugs or medications shall be stored in the facility. All drugs not used shall be destroyed in accordance with established policies and returned to the issuing Pharmacy for credit. Resident #7 was admitted with diagnoses including Type 2 Diabetes, Chronic Obstructive Pulmonary Disease (COPD), and Chronic Kidney Disease. The Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 15, which indicated that Resident #7 had intact cognition. The Quarterly Minimum Data Set assessment documented that Resident # 7 received a scheduled pain medication regimen. The Quarterly Minimum Data Set assessment documented Resident #7 had an indwelling catheter (a flexible tube inserted into the bladder to drain urine). A Physician's order dated 12/7/2024 documented Acetaminophen 325 milligrams, 2 tablets every 6 hours as needed for Pain. A Physician's order dated 12/13/2024 documented Lidocaine 5 percent ointment applied to the tip of the penis twice a day PRN (as needed). The order was discontinued on 5/16/2025. A review of Resident #7's Electronic Medical Record revealed no order for Glucose 4-gram tablets. A review of Resident #7's Electronic Medical Record revealed that Resident #7 did not have an assessment to self-administer any of their medications. A Pain assessment dated [DATE] documented that Resident #7 was at risk for pain and had a history of pain. The Pain Assessment documented that Resident #7 had no current complaint of pain. A Comprehensive Care Plan (CCP) titled Diabetes, dated 12/8/2024, documented interventions including the administration of medication and observing signs and symptoms of hypoglycemia (low blood sugar), including sweating, pallor (abnormal paleness), chills, weakness, anxiety, and lethargy (state of fatigue, drowsiness, and lack of energy). A Comprehensive Care Plan (CCP) titled Pain, dated 12/18/2024, documented interventions including the administration of medication and monitoring the effectiveness of medications. During an observation on 7/15/2025 at 10:11 AM, Resident #7 was in bed with an overbed table in front of them. A labeled Lidocaine 5 percent tube of ointment was observed on top of the overbed table next to a transparent, half-opened plastic container. The plastic container was observed with two unlabeled bottles containing glucose tablets. There was no Nurse within the vicinity of Resident #7's room. Resident #7 stated that the Lidocain ointment was being applied by the Nurses to their back with each incontinence change. Resident #7 stated that the glucose tablets were brought from home, and they had never used them at the facility. During an interview on 7/15/2025 at 10:30 AM, the Assistant Director of Nursing Services, who was also the Medication Nurse, stated that Resident #7 should not have any medications stored in their room. The Assistant Director of Nursing Services stated that Lidocaine ointment was discontinued back in May 2025 and was ordered for Foley Catheter changes. The Assistant Director of Nursing Services stated (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	they did not know the resident had glucose tablets stored in their room. During an interview on 7/16/2025 at 2:21 PM, Registered Nurse #1, Unit Manager, stated that Resident #7 should not have had any discontinued medications stored in their room. Registered Nurse #1 stated they did not initiate a self-administer medication assessment before because they (Nurses) did not know that Resident #7 had medications stored in their room that were brought from home. During an interview on 7/18/2025 at 12:53 PM, the Director of Nursing Services stated the facility staff should be observant of their environment, and any medications found in the resident's room should be reported and taken out. The Director of Nursing Services stated that the facility accommodated any request for self-administration of medication from residents after the residents were assessed for their cognitive ability, physical capability, and medication knowledge. The Director of Nursing Services stated that Resident #7 should not have any medications in their room, and if Resident #7 requested to self-administer any of their medication, the facility staff would have initiated a self-administration assessment. 10NYCRR 415.18(e) (1-4)

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F 0636 Level of Harm - Potential for minimal harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews during the Recertification Survey initiated on 7/15/2025 and completed on 7/22/2025, the facility did not ensure all comprehensive resident assessments were completed according to the Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual, including the Minimum Date Set assessment completion date must be no later than 14 days after the Assesssment Reference date. This was identified for one (Resident #44) of six residents reviewed for the Resident Assessment Task. Specifically, Resident #44's Annual Minimum Data Set assessment, with Assessment Reference Date of 10/3/2024, was not completed until 11/13/2024, 27 days after the completion due date.The finding is:The facility's policy and procedure titled Minimum Data Set 3.0, last revised 4/25/2025, documented that all Minimum Data Set assessments will adhere to the guidelines set forth by the Center for Medicare and Medicaid Services (CMS) and the New York State Department of Health. Each department is expected to complete its assigned responsibilities no later than 14 days from the Assessment Reference Date (ARD) and/or a completion date set by the facility's Minimum Data Set Coordinator as per the regulatory guidelines.Resident #44 was admitted with diagnoses including Metabolic Encephalopathy (a series of neurological disorders that affect the brain), Dementia, and Dysphagia. The Annual Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 11, indicating the resident had moderate cognitive impairment.The Annual Minimum Data Set, with an assessment reference date of 10/3/2024, was documented as completed on 11/13/2024, which was 27 days past the completion due date of 10/17/2024.During an interview on 7/18/2025 at 11:19 AM, the Minimum Data Set Coordinator stated they were responsible for the timely completion of Minimum Data Set assessments. The Minimum Data Set Coordinator stated Resident #44's Minimum Data Set assessment dated [DATE] should have been completed on or before 10/17/2024,14 days after the assessment reference date. The Minimum Data Set Coordinator stated they might have selected the wrong completion date (11/13/2024) and did not realize the mistake. During an interview on 7/18/2025 at 12:52 PM, the Director of Nursing Services stated they were not familiar with the timeframe requirements for the completion of Minimum Data Set assessments. The Director of Nursing Services stated that the Minimum Data Set Coordinator should ensure that the Minimum Data Set assessments are completed within the regulatory timeframe.During an interview on 7/18/2025 at 2:17 PM, the Administrator stated they were not familiar with the timeframe requirements for the completion of Minimum Data Set assessments. The Administrator stated they expected the Minimum Data Set assessments to be completed within the regulatory timeframe. The Administrator stated they were not aware that Resident #44's Minimum Data Set assessment was not completed on time. The Administrator stated that the Minimum Data Set Coordinator did not report to the facility Administrator. The Administrator stated that the Minimum Data Set Coordinator reports to the Corporate Minimum Data Set Coordinator, who was responsible for overseeing, providing guidance, and support related to Minimum Data Set assessments.10 NYCRR 415.11(a)(3)(i)

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews during the Recertification Survey initiated on 7/15/2025 and completed on 7/22/2025, the facility did not ensure that all completed Minimum Data Set assessments were electronically transmitted to the Center for Medicare and Medicaid Services within 14 days of the resident assessment completion. This was identified for one (Resident #44) of six residents reviewed for the Resident Assessment Task. Specifically, Resident #44's Quarterly Minimum Data Set assessment dated [DATE] and Annual Minimum Data Set assessment dated [DATE] were transmitted more than 14 days after the assessment completion date. Additionally, there was no documented evidence that Resident #44's Significant Change in Status assessment dated [DATE] was transmitted to the Center for Medicare and Medicaid Services. The finding is:The facility's policy and procedure titled Minimum Data Set 3.0, last revised 4/25/2025, documented that all Minimum Data Set assessments will adhere to the guidelines set forth by the Center for Medicare and Medicaid Services (CMS) and the New York State Department of Health. Each department is expected to complete its assigned responsibilities no later than 14 days from the Assessment Reference Date (ARD) and/or a completion date set by the facility's Minimum Data Set Coordinator as per the regulatory guidelines. The policy did not document the procedure related to the transmission of any Minimum Data Set assessments.Resident #44 was admitted with diagnoses including Metabolic Encephalopathy, Dementia, and Dysphagia. The Quarterly Minimum Data Set assessment dated [DATE] documented Resident #44 had a Brief Interview for Mental Status score of 7, which indicated the resident had moderate cognitive impairment. The Quarterly Minimum Data Set assessment dated [DATE] was completed on 6/6/2024. A review of the Minimum Data Set 3.0 Nursing Home Validation Reports provided by the facility revealed the following:Resident #44's Quarterly Minimum Data Set assessment with the assessment reference date of 5/23/2024 was completed on 6/6/2024 and electronically transmitted to the Center for Medicare and Medicaid Services on 6/24/2024, 4 days past the due date of 6/20/2024.The message on the report indicated that the record was submitted late: the submission date was more than 14 days after the assessment completion date.Resident #44's Annual Minimum Data Set assessment with the reference date of 10/3/2024 was completed on 11/13/2024 and electronically transmitted to the Center for Medicare and Medicaid Services on 12/27/2024, 30 days past the due date of 11/27/2024. The message on the report indicated that the record was submitted late: the submission date was more than 14 days after the assessment completion date.Resident #44's Significant Change in Status Minimum Data Set (MDS) assessment, dated 3/10/2025, was completed on 3/14/2025; however, there was no documented evidence that the assessment was electronically submitted to the Centers for Medicare and Medicaid Services within 14 days of the assessment completion date.During an interview on 7/18/2025 at 11:19 AM, the Minimum Data Set Coordinator stated they were responsible for ensuring Minimum Data Set assessments were submitted on time. The Minimum Data Set Coordinator stated that all Minimum Data Set assessments should be transmitted to the Centers for Medicare and Medicaid Services within 14 days of completion. The Minimum Data Set Coordinator stated Resident #44's Quarterly Minimum Data Set assessment, dated 5/23/2024, was completed on 6/6/2024 and should have been transmitted by 6/20/2024. The Annual Minimum Data Set assessment, dated 10/3/2024, was completed on 11/13/2024 and should have been transmitted by 11/27/2024. The Significant Change in Status Minimum Data Set assessment, dated 3/10/2025, was completed on 3/14/2025 and should have been transmitted by 3/28/2025. The Minimum Data Set Coordinator stated there were significant changes to the Resident Assessment Instrument process back in October 2024, which impacted the timeliness of transmission. The Minimum Data Set Coordinator stated they had encountered technical difficulties on occasion when assessments were electronically (continued on next page)

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	submitted to the Center for Medicare and Medicaid Services. The Minimum Data Set Coordinator stated they did not verify whether the assessments were transmitted timely and successfully because the facility's electronic program, which was used to track assessment transmission, did not issue any alerts. During an interview on 7/18/2025 at 12:52 PM, the Director of Nursing Services stated they were not familiar with the timeframe requirements for the transmission of Minimum Data Set assessments. The Director of Nursing Services stated that the Minimum Data Set Coordinator should ensure that the Minimum Data Set assessments are transmitted within the regulatory timeframe.During an interview on 7/18/2025 at 2:17 PM, the Administrator stated they were not familiar with the timeframe requirements for the transmission of Minimum Data Set assessments. The Administrator stated they expected the Minimum Data Set assessments to be transmitted within the regulatory timeframe. The Administrator stated they were not aware that Resident #44's Minimum Data Set assessments were not transmitted on time. The Administrator stated that the Minimum Data Set Coordinator did not report to the Administrator. The Administrator stated that the Minimum Data Set Coordinator reported to the Corporate Minimum Data Set Coordinator, who was responsible for overseeing the Minimum Data Set transmission process and providing guidance and support. 10 NYCRR 415.11