STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335342	A. Building B. Wing	05/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Westchester Restorative Therapy & Nrsg Crt	3550 Lexington Avenue Mohegan Lake, NY 10547

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review during an abbreviated survey (NY00370400) the facility did not ensure a comprehensive care plan was developed and implemented for each resident, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs for 1 out of 3 residents (Resident #2) reviewed for care planning. Specifically, Resident #2 who had impairment to one upper extremity and was dependent on staff for toileting, bed mobility and transfers, did not have an at risk for abuse care plan in place. On 1/27/2025 Resident #2 reported to their representative that a certified nurse aide threw a television remote control at them, and it hit them in the face. The facility concluded the allegation was unfounded The Findings are: The facility Comprehensive Care Plans and Resident/Patient Meeting policy dated August 2024 documented a comprehensive care plan for resident's needs should be developed by 14 days of admission and no later than 21 days. Resident #2 was admitted with diagnoses including but not limited to Pyogenic Arthritis, Depression and Bipolar disorder. A Quarterly Minimum Data Set, dated [DATE] documented the resident was cognitively intact. The resident had impairment on one side to the upper extremity and required a wheelchair for locomotion. The resident required set up assistance with meals and was dependent for toileting, bed mobility and transfers. Review of a communication care plan initiated 8/27/2024 documented Resident #2 was able to communicate and make needs known adequately. Interventions listed included anticipate all needs and provide the same if not contraindicated and validate comprehension by reflecting residents message. There was no documented evidence of Resident #2 having a risk for abuse care plan initiated until 1/30/2025, after the reported alleged incident on 1/27/2025. Call placed to the Director of Nursing on 5/13/2025 at 10:04 AM to interview regarding care plan implementation, unable to reach and voicemail left with no call back. 10 NYCRR 415.11(c)(1)

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 - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews during an abbreviated survey (NY00375176) the facility did not ensure that residents receive treatment and care in accordance with professional standards of practice for 2 out of 3 residents (Resident #1, Resident #3) reviewed for medications. Specifically, (1) review of Resident #1's medication administration record for November 2024 revealed their blood pressure medication was not administered on 11/23/2024. There was no documented evidence of any hold parameters for Resident #1's medication and no documented evidence of the Physician being informed of the medication hold. Review of Resident #1's medication administration record for December 2024 revealed the resident refused their asthma medication on 12/11/2024 and their blood pressure medication on 12/12/2024 and 12/13/2024. There was documented evidence of the Physician being made aware of Resident #1's medication refusals. (2) Review of Resident #3's medication administration record revealed they refused all of their oral medications on the 7 AM to 3 PM shift on 10/1/2024. There was no documented evidence that the Physician was made aware of Resident #3's refusals. The Findings are: The facility Medication Refusal policy last revised 11/4/2024 documented the resident has the right to refuse medications as desired. The facility will educate the resident on the importance of the medication and will reoffer before indicating refused. The resident will be encouraged to take the medication as ordered. The nurse will explain the name of the medication and what it is ordered for and the importance of following the prescribed medical regimen. If the resident continues to refuse despite this education, the nurse will document in the electronic medical record, not administered, refused. No later than after three refusals, the nurse will notify the Physician/Nurse Practitioner/Physicians Assistant of the resident's refusal and will document the same. Medications will be given according to the physician's orders and will be held in accordance to the written instructions and parameters indicated in the physician order. Resident #1 admitted to the facility on [DATE] with diagnoses including but not limited to Moderate Persistent Asthma, Essential Hypertension and Spinal Stenosis. A 5-day Scheduled Assessment Minimum Data Set, dated [DATE] documented the resident was cognitively intact. The resident required supervision for eating, maximal assistance for bed mobility and was dependent for toileting and transfers. Review of a cardiovascular dysfunction care plan initiated 10/25/2024 documented Resident #1 was at risk for cardiovascular dysfunction related to hypertension. Interventions listed included monitor for signs and symptoms of cardiovascular dysfunction and administer medication as per physician's order. Review of a respiratory care plan initiated 10/25/2024 documented Resident #1 had moderate persistent asthma with a potential for respiratory distress. Interventions listed included monitor for signs and symptoms of respiratory distress and infection and administer medications as per physician's order. Review of a communication care plan initiated 10/29/2024 documented Resident #1 was able to communicate adequately and make their needs known. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician's order dated 10/25/2024 documented Metoprolol succinate 25 mg, extended release 24-hour tablet- give one tablet by mouth once daily, every day at 9:00 AM. A physician's order dated 10/25/2024 documented Montelukast 10 mg tablet-give one tablet by mouth once daily in the evening, every day at 9:00 PM. Review of Resident #1's medication administration record for November 2024 revealed Metoprolol Succinate extended release (ER) 25 mg was not administered on 11/23/2024, documented due to within normal limits. There was no documented evidence of any hold parameters for Resident #1's medication. Review of Resident #1's medication administration record for December 2024 revealed: -Montelukast 10 mg was not administered on 12/11/2024 at 9:00 PM, documented refused. -Metoprolol succinate 25 mg was not administered on 12/12/2024 or 12/13/2024, documented refused. There was no documented evidence that the Physician was made aware of Resident #1's medication refusals. 2) Resident #2 admitted to the facility on [DATE] with diagnoses including but not limited to Dementia, Chronic Obstructive Pulmonary disease and Major Depressive disorder. A Quarterly Minimum Data Set, dated [DATE] documented Resident #3 had severe cognitive impairment. The resident required a walker or a wheelchair for locomotion. The resident required supervision for eating, maximal assistance with bed mobility and was dependent for toileting and transfers. Review of a cognitive loss/dementia care plan initiated 4/5/2024 documented Resident #3 had dementia as evidenced by difficulty in decision making and inappropriate verbal responses. Interventions listed included provide reality orientation and observe for changes in cognitive function. Review of a psychotropic drug use care plan initiated 11/9/2023 documented Resident #3 was taking antidepressants for a diagnosis of Major Depressive disorder. Interventions listed included administer psychotropic medications as ordered and assess mood, behavior patterns an changes in affect. Review of Resident #3's medication administration record for October 2024 revealed the resident refused all their oral medications on 10/1/2024. There was documented evidence of the Physician being made aware of Resident #3's refusals. During an interview on 5/1/2025 at 12:57PM the Nurse Practitioner stated if a resident refuses medications, then the nurses will usually report it to them and that Resident #1 was not the type to refuse their medications. The Nurse Practitioner stated there were no hold parameters on Resident #1's Metoprolol and they were supposed to take this medication daily. The Nurse Practitioner stated Resident #1's family representative asked about the resident's heart rate and their Metoprolol medication, and they recommended they speak to cardiology after the resident was discharged . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/1/2025 at 2:07 PM Licensed Practical Nurse #4 stated if a resident refuses their medication, then they have to let the Physician, or the Nurse practitioner know. Licensed Practical Nurse #4 stated if after hours, they let the Physician know, but during the day they inform the Nurse practitioner as they are in the facility. Licensed Practical Nurse #4 stated they should also write a progress note about the resident's refusal. Licensed Practical Nurse #4 stated they did not write progress note regarding Resident #1's medication refusal on 12/12 2024 and this was an oversight. Licensed Practical Nurse #4 stated the Nurse Practitioner is in the facility and if the resident refuse, they will walk over to their office with a list of resident refusals to inform them of what was missed, but they should also write a note about the missed medications. During an interview on 5/1/2025 at 2:31 PM Registered Nurse #1 stated when a resident refuses their medication, they will speak to the resident and teach them about the benefits of taking their medication. Registered Nurse #1 stated they will also reapproach and provide encouragement to the resident and the resident will usually take the medication. Registered Nurse #1 stated if the resident continues to refuse the medication, they will let the Physician know and they would also write a progress note regarding the refusal. Registered Nurse #1 stated the did not recall, not administering Resident #1's Metoprolol on 11/23/2024, but they documented within normal limits because the residents blood pressure and heart rate were normal. During an interview on 5/1/2025 at 3:01 P:M the Director of Nursing stated if a resident refuses their medication, then the nurses are supposed to notify the Physician and educate the resident. The Director of Nursing stated the nurses should also be documenting the refusal in a progress note in the resident's chart. 10 NYCCRR 415.12

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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 interviews during an abbreviated survey (NY00370400), the facility did not maintain medical records on each resident that are complete and accurately documented in accordance with accepted professional standards and practices for 1 out of 3 residents (Resident #2) reviewed for documentation. Specifically, on 1/28/2025 Resident #2 reported to their representative that a Certified Nurse Assistant threw a television remote control at them hitting them on the face. Review of Resident #3's medical chart revealed no documented evidence of any nursing or medical assessment completed pertaining to Resident #2's allegation that occurred on 1/27/2025. The findings are: The facility Documentation policy last reviewed 9/14/2024 documented it is the policy of the facility to document all information related to the patient's medical care either in the electronic medical record or in the resident's paper chart. The purpose is to maintain all information regarding the resident's care and treatment in an organized manner to ensure residents receive appropriate medical care with appropriate documentation. All documentation related to resident's general condition will be charted in the medical record in many different areas based on the type of documentation needed. Documentation will occur with change in condition and events and continue until the problem is solved. Progress notes are interim notes written at the time of an incident and/or change in condition, notification of family members may be done in person, on site or via telephone. These notes indicate the discipline, date and time of entry and person signing the entry. Resident #2 was admitted to the facility on [DATE] with diagnoses including but not limited to Pyogenic Arthritis, Depression and Bipolar disorder. A Quarterly Minimum Data Set, dated [DATE] documented the resident was cognitively intact. The resident had impairment on one side of the upper extremity and required a wheelchair for locomotion. The resident required set up assistance with meals and was dependent for toileting, bed mobility and transfers. Review of the undated investigative summary documented at 5:05 PM on 1/28/2025 the Director of Nursing was leaving the facility and was informed by the Social Worker that Resident #2's representative called and reported that Resident #2 informed them that a Certified Nurse Assistant had thrown a television remote control that landed on their face on 1/27/2025. There were no documented progress notes in Resident #2's chart reflecting the allegation made on 1/28/2025, or a body audit form being completed for the resident. There was no documented progress note from the Physician documenting assessment of Resident #2 after the reported allegation on 1/28/2025. There was no progress note documented in Resident #2's medical chart, regarding the Social Worker seeing and assessing the resident after the report they received from Resident #2's representative. A written statement from the Social Worker dated 1/30/2025 was attached to the investigative summary. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/1/2025 at 12:57 PM, the Nurse Practitioner stated they heard about the allegation involving Resident #2 and the facility did an investigation. The Nurse Practitioner stated they were not asked to assess the resident after the allegation/incident that occurred on 1/27/2025. During a telephone interview on 5/7/2025 2:33 PM, Registered Nurse #3 stated if there is an alleged abuse the incident is not documented in Sigma (the electronic medical health record). This is usually documented in the incident report and the Director of Nursing will do the investigative summary and report it to the Department of Health. During an interview on 5/1/2025 at 3:01 PM, the Director of Nursing stated they have never had the documents from the reportables in the resident's charts and these incidents are kept in a file in their office. 10 NYCRR 415.22(a)(1-4)