STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335398	A. Building B. Wing	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sans Souci Rehabilitation and Nursing Center	115 Park Avenue Yonkers, NY 10703

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review conducted during the abbreviated survey, the facility did not ensure residents received care consistent with professional standards of practice to prevent and promote healing of pressure ulcers for one of three residents (Resident # 4) reviewed for pressure ulcers. Specifically, Resident #4 had deep tissue injuries to both feet and heel booties, recommended by the wound care consultant on 10/29/2024, were not implemented until after 01/07/2025.The findings include:Resident #4 had diagnoses including Arthritis, Muscle weakness, and malnutrition.The 7/28/2024 admission Minimum Data Set (resident assessment) documented moderately impaired cognition, impairments to both upper extremities. Resident #4 required substantial/maximal assistance with bed mobility and had no unhealed pressure ulcers.The 7/23/2024 At Risk for Pressure Injury Care Plan did not document interventions for offloading or heel booties.The 9/18/24 Medicare 5-day Minimum Data Set (resident assessment) documented Resident #4 had no unhealed pressure ulcers.Resident #4 was transferred to the hospital on 9/23/24 and returned to the facility on [DATE].The 10/22/2024 Nursing admission Assessment documented one surgical incision, and deep tissue injuries to both feet.The10/28/24 quarterly Minimum Data Set (resident assessment) documented two unstageable pressure ulcers (wound where the true depth and tissue damage are hidden because dead tissue completely covers the wound bed and the depth cannot be assessed) present on admission.The 10/29/2024 Wound Consult written by Physician's Assistant #3 documented four deep tissue injuries and one surgical wound. The Additional Orders documented Offloading. Facility pressure injury prevention protocol, other: heel booties.The 10/22/2024 and 10/30/2024 Braden scale scores (risk for skin injury) were high.There was no documented evidence of the presence of heel booties or off-loading heels in the physician's orders or in the certified nurse aide tasks.The 11/05/2024 Wound Consult written by Physician's Assistant #3 documented a right dorsal foot deep tissue injury measuring 15.0 centimeters by 1.9 centimeters, a left medial forefoot deep tissue injury not measured, a surgical neck wound, and a left lateral foot deep tissue injury, resolved. Additional Orders documented Offloading, Facility pressure injury prevention protocol, other: heel booties.The 11/12/2024 Wound Consult written by Physician's Assistant #3 documented right dorsal foot deep tissue injury measuring 7.4 centimeters by 2.3 centimeters by 0 centimeters, a left medial forefoot deep tissue injury measuring 6.8 centimeters by 2.1 centimeters, a surgical neck wound, a left lateral foot deep tissue injury persistent non-blanchable deep red, maroon or purple discoloration pressure ulcer. The General Notes documented 100% purple tissue. The Additional Orders documented Offloading facility pressure injury prevention protocol, other: heel bootiesThe 11/12/2/024 care plan actual pressure ulcers as evidenced by deep tissue injuries to Resident #4's left lateral foot, left medial foot, and right dorsal foot related to disease process did not document interventions for offloading or heel booties.The 11/19/2024 Wound Consult written by Physician's Assistant #3 documented a right dorsal foot deep tissue injury measuring 13.2 centimeters by 1.9 centimeters, a left medial forefoot deep tissue injury measuring 7.6 centimeters by 1.9 centimeters, a surgical neck wound, a left lateral foot deep tissue injury measuring 4.7 centimeters by 1.0 centimeters, a left thigh stage 2 pressure ulcer measuring 3.4 centimeters by 0.9 centimeters by 0.1 (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	centimeters. The Additional Orders documented offloading, facility pressure injury prevention protocol, other: heel booties.The 1/06/2026 update to the At Risk for Pressure Injury Care Plan interventions did not document interventions for offloading or heel booties.The 1/07/2025 Wound Consult written by Physician's Assistant #4 documented a right heel stage three pressure ulcer measuring 2.3 centimeters by 1.0 centimeters by 0.1 centimeters, a left medial forefoot deep tissue injury measuring 0.8 centimeters by 0.6 centimeters, a right dorsal foot deep tissue injury measuring 5.2 centimeters by 1.2 cm, a left lateral foot unstageable wound measuring 5.2 centimeters by 0.7 centimeters by 0.5 centimeters. Multiple wounds noted to both feet. The left lateral forefoot wound had deteriorated and was unstageable. Requesting heel boots. Strict offloading and turning and repositioning every one to two hours in bed, discussed with the facility Director of Nursing. The General Notes documented requesting heel boots, heel boots needed. The Additional Orders documented pressure injury prevention protocol, other: heel booties.On 6/24/2026 at 9:35 AM during interview and record review with Licensed Practical Nurse Charge Nurse #3, they reviewed the 10/22/2024 nursing admission assessment which documented deep tissue injuries to both feet. They reviewed the 10/29/2024, 11/05/2024, 11/12/2024, 11/19/2024 wound consults which documented offloading with heel booties. They stated they could not find documentation of the use of heel booties or that staff were off-loading Resident #4's heels in the physician's orders or in the certified nurse aide tasks. They reviewed the 1/07/2025 wound consult which documented the resident had multiple wounds noted to both feet and the left lateral forefoot wound had deteriorated and was unstageable, requesting heel booties, discussed with the facility Director of Nursing. They stated that no heel booties were documented. They stated that Resident #4 should have had heel booties to offload their feet with wounds present.On 6/25/2026 at 1:45 PM during an interview and a follow-up interview on 6/26/26 at 8:54 AM with the Director of Nursing, they reviewed the 10/22/2024 nursing admission assessment, the 10/29/2024, 11/05/2024, 11/12/2024, 11/19/2024 wound consults and stated they could not find documentation of the use of heel booties or that staff were off-loading Resident #4's heels in the physician's orders or in the certified nurse aide tasks. They reviewed the 1/07/2025 wound consult which documented the resident had multiple wounds noted to both feet and the left lateral forefoot wound had deteriorated and was unstageable, requesting heel booties, discussed with the facility Director of Nursing. They stated that the admission nurse who performed the admission assessment was responsible for initiating heel booties in the certified nurse aide tasks and the care plan based on the resident's assessment and risk for skin breakdown. They stated that Resident #4 was re-admitted on [DATE] with deep tissue injuries to both feet, they should have had heel booties in place.On 6/26/2026 at 2:36 PM during an interview with Physician Assistant #3, they stated that offloading was paramount for wound healing. They further stated that without offloading, wounds might not heal. They stated they expected the facility to carry out their recommendations. On 6/26/2026 at 2:49 PM during an interview with Physician Assistant #4, they stated that offloading was crucial for wound prevention and wound healing. They stated it was their expectation that the facility would carry out their recommendations. 10 New York Codes, Rules and Regulations 415.12(c)(1)