STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335424	A. Building B. Wing	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martine Center for Rehabilitation and Nursing	12 Tibbits Avenue White Plains, NY 10606

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49372 Based on record review and interviews during an abbreviated survey (NY00352478), the facility did not ensure the Minimum Data Set assessment accurately reflected the resident's status for 1 out of 3 residents reviewed for assessments. Specifically, Resident #1's Quarterly Minimum Data Set assessment dated [DATE] coded the resident as dependent for all cares with 2-person assistance. The Quarterly Minimum Data Set, dated dated dated [DATE] coded the resident as dependent but requiring a 1 person assist which is not indicative of dependence for care. In addition, staff interview revealed a discrepancy on Resident #1's required assistance with bed mobility and the Certified Nurse Assistant Task Instructions/Accountability did not accurately reflect required assistance for Resident#1. Findings include: The facility Minimum Data Set 3.0 policy dated 5/2017 documented the Resident Assessment Instrument process and requirement procedure are as follows: the assessment accurately reflects the resident's status, the assessment process includes direct observation, as well as communication with the resident and direct care staff. Resident #1 was initially admitted to the facility on [DATE] and last readmitted on [DATE] with diagnosis including but not limited to Parkinson's disease, Schizophrenia and Dementia. A Quarterly Minimum Data Set, dated dated dated [DATE] documented the resident had impairment on both sides to upper and lower extremities. The resident was dependent for eating, toileting, bed mobility and transfers. No bed rails in use. The Minimum Data Set coding documented dependent for tasks signifies helper does all the effort. Resident does none of the effort to complete the activity or, the assistance of 2 or more helpers is required for the resident to complete the activity. A Quarterly Minimum Data Set, dated dated dated [DATE] documented the resident had impairment of their upper extremity on one side and impairment to both lower extremities. The resident was dependent for bed mobility, toileting, and transfers with 2-person assistance. Review of the Minimum Dat Set dated 11/6/2023, 02/04/2024, 05/06/2024 revealed the resident had impairment to both upper extremities and one lower extremity. The resident was dependent for eating, bed mobility and transfers. Documented no bed rail in use. (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a nursing quarterly evaluation dated 02/04/2024, 05/06/2024, 08/06/2024 revealed the resident was dependent for bed mobility with 1-person physical assist. The mobility section documented the resident was bedfast and had very limited mobility with changing and controlling body position. Review of a quarterly assessment dated [DATE] documented that for activities of daily living the resident required x 2 staff total dependence, resident does not participate in activity at all for bed mobility. The mobility section documented the resident was dependent for bed mobility with a 1-person physical assist. The skin section documented the resident was completely immobile, does not make even slight changes in body or extremity position without assistance. Review of a quarterly evaluation dated 07/31/2023 documented the resident was completely immobile, does not make even slight changes in body or extremity position without assistance, and required x 2 staff total dependence, resident does not participate in activity at all for bed mobility. The Care Plan and the Certified Nurse Assistant accountability/task instruction did not accurately reflect the required assistance for a resident dependent for all cares as indicated. During an interview on 09/19/2024 at 1:25 PM, Certified Nurse Assistant #2 stated they recall Resident #1 required assist of 1 person for tasks in the computer. Certified Nurse Assistant #2 stated whenever they provided cares to Resident #, they would always get another certified nurse assistant to help them because the resident was heavy. During an interview on 09/19/2024 at 1:49 PM, Certified Nurse Assistant #4 stated they had worked with Resident #1 before and they needed 2 people assist, especially without the side rails. Certified Nurse Assistant #4 stated Resident #1 was stiff, and their leg stuck out and if you are not familiar with them and turn them, they can fall right off the bed. During an interview on 09/19/2024 at 3:38 PM, Certified Nurse Assistant #1 stated they were familiar with Resident #1 and had worked with them before the incident. Certified Nurse Assistant #1 stated that Resident #1 was a 1 person assist for bed mobility and cares. Certified Nurse Assistant #1 stated they feel Resident #1 needed to be cared for by 2 people, and they could have told the nurse or the supervisor, but they did not. During an interview on 09/20/2024 at 1:38 PM, the Physical Therapist stated when they receive a referral from nursing for a long-term resident, they would evaluate the resident and inform nursing of any recommendations and nursing then updates the computer with the recommendations from the rehabilitation department. The Physical Therapist stated to determine if a dependent resident needs a 1 to 2 person assist depends on the therapist's judgement and if they did an evaluation and they were able to complete the evaluation independently on the unit without the assistance of another staff member or therapist, then the resident may require a 1 person assist. The Physical Therapist stated if they had trouble and needed another therapist or staff member to assist them with the resident's evaluation, then they would recommend a 2 person assist. (continued on next page)

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/20/2024 at 1:38 PM the Physical Therapist stated when they receive a referral from nursing for a long-term resident, they would evaluate the resident and inform nursing of any recommendations and nursing then updates the computer with the recommendations from the rehabilitation department. The Physical Therapist stated to determine if a dependent resident needs a 1 to 2 person assist depends on the therapist's judgement and if they did an evaluation and they were able to complete the evaluation independently on the unit without the assistance of another staff member or therapist, then the resident may require a 1 person assist. Stated if they had trouble and needed another therapist or staff member to assist them with the resident's evaluation, then they would recommend a 2 person assist. During a telephone interview on 9/20/2024 at 2:09 PM, the Registered Nurse Minimum Data Set Coordinator stated they have been working in the facility for 4 years. The Registered Nurse Minimum Data Set Coordinator stated they sometimes residents' assessments are done in the facility in person, but other times they do not have an assessor, so the bulk of the Minimum Data Set books are done offsite. The Registered Nurse Minimum Data Set coordinator stated they use the assessments completed by the nurses on the unit to complete their Minimum Data Set and if something does not add up in the documentation, they will then go back and check on the information themself. The Registered Nurse Minimum Data Set Coordinator stated they also review the previous books to make sure that nothing has changed from the last assessment. 10 NYCRR 415.11(b)

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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** 49372 Based on record review and interview during an abbreviated survey (NY00352478, NY00350699), the facility did not ensure that a comprehensive person-centered care plan was developed and implemented to ensure services were provided to maintain the residents' highest practicable physical, mental, and psychosocial well-being for 1 out of 3 residents reviewed for activities of daily living. Specifically, there was no documented evidence that a comprehensive care plan was initiated after the Quarterly Minimum Data Set assessment dated [DATE], that documented that the resident was dependent for all cares. In addition, the care plan did not accurately reflect the required assistance for a resident dependent for all cares on the Certified Nurse Assistant Task Instructions/Accountability. Resident #1 fell out of bed while Certified Assistant #1 was providing cares alone without rails and sustained lacerations to the forehead, and right nares and possible cervical fracture. The findings are: The facility Care Plan Comprehensive policy dated 10/2015 and last revised 10/2019 documented the care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. Assessments of the resident are ongoing and care plans are revised as information about the residents and resident's condition change, when the resident has been readmitted to the facility from the hospital and at least quarterly with scheduled Minimum Data Sets. Resident #1 was last readmitted to the facility on [DATE] with diagnosis including but not limited to Parkinson's disease, Schizophrenia and Dementia. A Quarterly Minimum Data Set, dated dated dated [DATE] documented the resident had severe cognitive impairment with daily decision making. No behaviors documented. The resident had impairment on both sides to upper and lower extremities. The resident was dependent for eating, toileting, bed mobility and transfers. No bed rails in use. There was no documented evidence that a comprehensive care plan was initiated after the Quarterly Minimum Data Set assessment dated [DATE] that documented that the resident was dependent for all cares. During an interview on 09/19/2024 at 1:25 PM, Certified Nurse Assistant #2 stated they recall Resident #1 required assist of 1 person for tasks in the computer. Certified Nurse Assistant #2 stated whenever they provided cares to Resident #, they would always get another certified nurse assistant to help them because the resident was heavy. During an interview on 09/19/2024 at 1:49 PM, Certified Nurse Assistant #4 stated they had worked with Resident #1 before and they needed 2 people assist, especially without the side rails. Certified Nurse Assistant #4 stated Resident #1 was stiff, and their leg stuck out and if you are not familiar with them and turn them, they can fall right off the bed. (continued on next page)

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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	During an interview on 09/19/2024 at 3:38 PM, Certified Nurse Assistant #1 stated they were familiar with Resident #1 and had worked with them before the incident. Certified Nurse Assistant #1 stated that Resident #1 was a 1 person assist for bed mobility and cares. Certified Nurse Assistant #1 stated they feel Resident #1 needed to be cared for by 2 people, and they could have told the nurse or the supervisor, but they did not. During a telephone interview on 9/20/2024 at 2:09 PM, the Registered Nurse Minimum Data Set Coordinator stated they have been working in the facility for 4 years now. The Registered Nurse Minimum Data Set Coordinator stated they sometimes do assess the residents in the facility in person, but at this time they do not have an assessor, so the bulk of the Minimum Data Set books are done offsite. The Registered Nurse Minimum Data Set coordinator stated they use the assessments completed by the nurses on the unit to complete their Minimum Data Set and if something does not add up in the documentation they will then go back and check on the information themself. The Registered Nurse Minimum Data Set Coordinator stated they also review the previous books to make sure that nothing has changed from the last assessment. During an interview on 9/20/2024 at 2:30 PM, the Medical Director stated Resident #1 was a one person assist and they were care planned for that. The Medical Director stated the facility followed protocol, there was no change in Resident #1's need for care. The Medical Director stated Resident #1 had not experienced any falls and nothing had changed in the resident's physicality or contractures for the plan of care to be changed. The Medical Director stated the staff in the facility felt it was appropriate for the resident to have a 1 person assist for cares. During an interview on 9/20/2024 at 3:32 PM, the Director of Nursing stated residents should be evaluated by the rehabilitation department to determine if they are a 1 person or 2 person assist and the resident's Kardex is updated to ensure that everyone is aware of how to care for the resident. The Director of Nursing stated if there is a change in a resident's status, the staff should inform the nurse so the resident can be reevaluated. During an interview on 9/20/2024 at 4:03 PM, the Administrator stated they found out the resident had a fall from the Director of Nursing, and the case was clinically reviewed in morning report on 08/21/2024. The Administrator stated they asked if the incident resulted from a break in the care plan, because if this was a break in the care plan then they need to report the incident to the State. The Director of Nursing informed the Administrator that there was no need for an immediate report because there was no breech in the care plan. The Administrator stated they reviewed their processes and there was no break in the process. The Administrator stated that staff should tell the nurse or the nurse manager if there is a change in the resident's status, so that the resident can be reviewed by the interdisciplinary team and an order can be obtained for the rehabilitation department to evaluate them. The Administrator stated once the status of the resident is determined to need an update or a change, then the unit manager or head nurse would then update the task in the system. The Administrator stated the rehabilitation department would determine if the resident were a 1 person or a 2 person assist with cares. The Administrator stated the nurse manager updates the care plans. 10 NYCRR 415.11(c)(1)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49372 Based on record review and interview during an abbreviated survey (NY00350699), the facility did not ensure that a comprehensive person-centered care plan was reviewed and revised for 1 out of 3 residents (Resident #2) reviewed for care planning. Specifically, Resident #2 had a self-reported fall on 7/24/2024 and their actual fall care plan was not updated to reflect it. Findings include: The facility Care Plan Comprehensive policy dated 10/2015 and last revised 10/2019 documented the care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. Assessments of the resident are ongoing and care plans are revised as information about the residents and resident's condition change, when the resident has been readmitted to the facility from the hospital and at least quarterly with scheduled Minimum Data Sets. Resident #2 initially admitted to the facility on [DATE] and last readmitted on [DATE] with diagnosis including but not limited to Metabolic Encephalopathy, Hemiplegia affecting Left Dominant Side and Dysphagia Oropharyngeal Phase. A Quarterly Minimum Data Set, dated dated dated [DATE] documented the resident was rarely/never understood and had severe cognitive impairment with daily decision making. No behaviors documented. The resident had impairment on both sides of their lower extremities. The resident was dependent for toileting and required maximal assistance with bed mobility and transferring was not attempted. The resident was always incontinent of urine and bowel. No documented swallowing disorders and had a feeding tube. No restraints or alarms in use. Review of an accident/incident report dated 07/24/2024 at 2:00 AM documented Resident #2 reported they fell . The resident was found in left lateral position close to the side table. The bed was in the lowest position, left and right-side rails were down, and floor mat in place. The resident had a bump with redness to the back of their head. Actions documented assessment/documentation, call bell within reach with instructions, care plan updated, diagnostic studies, fall assessment completed, first aid initiated, floor mat, low bed, neuro checks initiated, pain assessment, refer to therapy and skin assessment completed. Resident #2 was transferred to the hospital for evaluation and their wife was at the bedside. Further review of the at risk for fall/ actual fall care plan revealed it was not updated to reflect the fall that occurred on 07/24/2024. During an interview on 09/20/2024 at 4:03 PM, the Administrator stated the nurse manager updates the care plans for the residents on the unit. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 10/1/2024 at 12:50 PM, the Registered Nurse Unit Manager 4th floor stated they were covering Resident #2's unit in July of 2024. Registered Nurse Unit Manager 4th floor stated they were told by staff that Resident #2's wife reported the resident had fallen out of bed at approximately 2:00 AM. Registered Nurse Unit Manager 4th floor stated they were informed about the incident late the next day and they did their initial assessment and reported the fall to the Director of Nursing. Registered Nurse Unit Manager 4th floor stated they would be the one responsible for updating the care plan for Resident #2's fall and that they did not document in the fall plan exactly, but they did do the enabler section. 10 NYCRR 415.11 (c)(2)(i-iii)

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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 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** 49372 Based on record review and interview during an abbreviated survey (NY00352478, NY00350699), the facility did not ensure the resident environment remained as free of accident hazards as is possible; and that each resident received adequate supervision and assistance to prevent accidents for 1 out of 3 residents reviewed for accidents. Specifically, on 8/21/2024, Resident #1 who had been identified as totally dependent with cares (helper completes all activities for the resident, resident does not use any of their own strength for any part of the activity), fell off the bed when Certified Nursing Assistant #1 was providing care by themself. Resident #1 sustained an unstable cervical spine C4-C5 fracture and possible left femoral neck fracture with deep forehead lacerations 4.5cm long and 0.1cm depth across forehead, swollen upper lip and gums and right nares. Resident #1's care plan documented resident required 1 person assist. Resident was transferred to the hospital for further medical evaluation. Findings include: The facility Safety and Supervision policy dated 11/2017 and last revised 02/01/2024 documented facility-oriented and resident-oriented approaches to safety are used together to implement a systems approach to safety, which considers the hazards identified in the environment and individual risk factors. The facility-oriented approach included identifying residents risk factors based on environmental hazards, developing action plans and interventions that are resident specific, supervision or assistive device use and temporary or permanent modification of the environment. The facility Minimum Data Set 3.0 policy dated 5/2017 documented the Resident Assessment Instrument process and requirement procedure are as follows: the assessment accurately reflects the resident's status, the assessment process includes direct observation, as well as communication with the resident and direct care staff. Resident #1 was initially admitted to the facility on [DATE] and last readmitted on [DATE] with diagnosis including but not limited to Parkinson's disease, Schizophrenia and Dementia. A Quarterly Minimum Data Set, dated dated dated [DATE] documented the resident had severe cognitive impairment with daily decision making. No behaviors documented. The resident had impairment on both sides to upper and lower extremities. The resident was dependent for eating, toileting, bed mobility and transfers. No bed rails were in use. (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the incident report dated 8/21/2024 documented Resident #1 fell off the bed while a staff member turned them over. The Incident Report documented no signs of pain observed, but Resident #1 sustained a cut to their forehead which seems painful. There were no preventive measures in place. The resident sustained 2 lacerations, one to their forehead and under their right nares. The investigative report conclusion documented Resident #1 is a one person assist with bed mobility. Return demonstration performed by Certified Nurse Assistant #1 with no negative findings. The resident had a severe contracture of their right leg; outward flexed from the hip, turning inward from the knee and the foot flexed pointing upward. The resident was also laying on an alternating air mattress. The resident will be re-evaluated by rehabilitation for bed mobility status and contracture maintenance upon return to the facility. This isolated incident, no abuse, mistreatment, neglect identified. Plan of care was followed. Review of Resident #1's hospital discharge summary dated 8/28/2024 documented Resident #1 was admitted for a fall off their bed while they were receiving care at the facility. The Discharge summary documented the presenting history as, Resident #1 showed an unstable cervical spine C4-C5 fracture and possible left femoral neck fracture. The resident is immobile and a functional quadriplegic and documented the principal diagnosis as neck fracture, cervical transverse process fracture. Review of a quarterly evaluation dated 02/17/2023, 05/17/2023 and 07/31/2023 documented the resident was completely immobile, does not make any slight changes in body or extremity position without assistance, and required x 2 staff total dependence, resident does not participate in activity at all for bed mobility. During an interview on 09/19/2024 at 1:30 PM, Licensed Practical Nurse #1 stated they have been working in the facility since 2017. Licensed Practical Nurse #1 stated they were Resident #1's primary nurse on 08/21/2024. Licensed Practical Nurse #1 stated Certified Nurse Assistant #1 came and told them that Resident #1 fell off the bed. Licensed Practical Nurse #1 stated they saw Resident #1 on the floor, the nursing supervisor assessed the resident, and they called 911. Licensed Practical Nurse #1 stated they applied a cold compress to Resident #1's forehead and their nose because they were bleeding then applied a dressing to the areas. Licensed Practical Nurse #1 stated Resident #1 was on the floor on their left side. Licensed Practical Nurse #1 stated there were no side rails on Resident #1's bed and that side rails are not used in the facility. Licensed Practical Nurse #1 stated Resident #1 was a 1 person assist with cares, but Resident #1 could not assist with their transferring or turning in bed. During an interview on 09/19/2024 at 1:25 PM, Certified Nurse Assistant #2 stated they recall Resident #1 required assist of 1 person for tasks in the computer. Certified Nurse Assistant #2 stated whenever they provided cares to Resident #, they would always get another certified nurse assistant to help them because the resident was heavy. During an interview on 09/19/2024 at 1:49 PM, Certified Nurse Assistant #4 stated they had worked with Resident #1 before and they needed 2 people assist, especially without the side rails. Certified Nurse Assistant #4 stated Resident #1 was stiff, and their leg stuck out and if you are not familiar with them and turn them, they can fall right off the bed. (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/19/2024 at 3:38 PM, Certified Nurse Assistant #1 stated they have been working in the facility for 5 months. Certified Nurse Assistant #1 stated they were the certified nurse assistant assigned to Resident #1 on 08/21/2024 on the 11 PM to 7 AM shift. They went into Resident #1's room at 6:00 AM to provide care. They turned Resident #1 to the left side towards the door. Certified Nurse Assistant #1 stated one of the resident's feet is contracted and turned upward, so when their foot hit the mattress, their entire body went over the edge of the bed. Certified Nurse Assistant #1 stated they tried to grab Resident #1 and could not catch them, and they fell on their face to the floor. Certified Nurse Assistant #1 stated Resident #1 did not have a side rail in place to the bed and they feel Resident #1 needed to be cared for by 2 people, however they did not inform the nurse or the supervisor. Certified Nurse Assistant #1 stated they did not ask for assistance from the other staff because the other staff were busy doing their own residents cares. During an interview on 09/20/2024 at 12:55 PM, the Registered Nurse Unit Manager of the 4th floor stated the resident could not hold onto the siderails with their hands. Registered Nurse Unit Manager of the 4th floor stated they answered the question wrong. Registered Nurse Unit Manager of the 4th floor stated based on the CMS guidelines and the audit that they completed the resident still would not have been a candidate for the siderails. Registered Nurse Unit Manager of the 4th floor stated according to the guidelines the side rails were more of a safety hazard if the resident's arm would have gotten caught in the rail they would not have been able to remove it. During an interview on 09/20/2024 at 2:30 PM, the Medical Director stated Resident #1 was a one person assist and they were care planned for this. The Medical Director stated the facility followed protocol and there was no change in Resident #1's need for care. The Medical Director stated Resident #1 had not experienced any falls and nothing had changed in the resident's physicality or contractures for the plan of care to be changed. The Medical Director stated the staff in the facility felt it was appropriate for the resident to have a 1 person assist for cares. During a telephone interview on 09/26/2024 at 1:03 PM, Registered Nurse Supervisor #1 stated they have been working in the facility since March 2021. Registered Nurse Supervisor #1 stated they were the night shift supervisor on duty on 08/21/2024 and at 6:00 AM Licensed Practical Nurse #1 called and told them that Resident #1 was on the floor. Registered Nurse Supervisor #1 stated they went to the unit and saw Resident #1 on the floor, laying between the 2 beds. Registered Nurse Supervisor #1 stated Resident #1 was laying on their right side almost face down and they could not see their face, so they approached them and bent down to touch them and turn the resident slightly so they could see their face. Registered Nurse Supervisor #1 stated when they moved Resident #1 over, they saw a small pool of blood on the floor and the resident had a little bit of blood on their forehead and their nose. Registered Nurse Supervisor #1 stated Licensed Practical Nurse #1 and Certified Nurse Assistant #1 were in the room with them, and they told them to call 911, because this was a major fall with injury. Registered Nurse Supervisor #1 stated they became anxious and upset because Resident #1 cannot walk or move, so they could not understand how this fall happened. (continued on next page)

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Martine Center for Rehabilitation and Nursing	12 Tibbits Avenue White Plains, NY 10606

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/20/2024 at 4:03 PM, the Administrator stated that staff should tell the nurse or the nurse manager if there is a change in the resident's status, so that the resident can be reviewed by the interdisciplinary team and an order can be obtained for the rehabilitation department to evaluate them. The Administrator stated once the status of the resident is determined to need an update or a change, then the unit manager or head nurse would then update the task in the system. The Administrator stated the rehabilitation department would determine if the resident were a 1 person or a 2 person assist with cares. The Administrator stated Resident #1 as per the CMS guideline was not appropriate for side rails and that this was discussed in an interdisciplinary team meeting as well. The Administrator stated their policy is based on the state regulations and the side rail assessments are completed quarterly. 10 NYCRR 415.12(h)(1)