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	08/25/2025

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 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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview during an abbreviated survey (NY00367889/591527, NY00333553/591524, NY00349962/591497) 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 3 of 5 residents (Resident #1, #2, #5) reviewed for care planning. Specifically, 1) Resident #1 had an unwitnessed fall on 01/1/2025 and sustained skin tears to both arms. Resident #1 had no documented fall risk or actual fall care plan initiated before or after the incident. 2) Resident #2 was noted to have eschar to their left heel on 02/11/2024. Resident #2's pressure injury care plan had not updated with the presence of the left heel eschar, measurements and/or tracking. 3)After a meeting with Resident #5's representatives on 04/18/2025, it was determined the resident would have a two person assist for all cares. Review of Resident #5's self-care care plan revealed it was not updated to reflect the two-person assistance for all cares. The findings are:The facility Care Plan Comprehensive policy last reviewed 08/2/2024 documented a comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The comprehensive, person-centered care plan will incorporate identified problem areas, and the risk factor associated with them.1) Resident #1 was admitted with diagnoses including but not limited to Polymyalgia Rheumatica, Asthma and Depression.An admission Minimum Data Set, dated [DATE] documented the resident had moderate cognitive impairment. The resident required a walker or a wheelchair for locomotion. The resident required set-up assistance with meals, moderate assistance with bed mobility and dependent for toileting, upper and lower body dressing and transfers. Review of an accident/incident report dated 01/01/2025 documented Resident #1 had an unwitnessed fall in their room. 0n 01/01/2025. The report documented the resident's bed was in the lowest position and the call bell was within reach.There was documented evidence of an actual fall care plan or risk for fall care plan initiated before and after the fall on 01/01/2025. There was no safety measures to prevent falls in place for the resident. During a telephone interview on 08/15/2025 at 11:50 AM, Registered Nurse #1 stated the nursing supervisor who responded to the incident is responsible to complete the incident report and update the fall care plans with interventions. Registered Nurse #1 stated the fall care plan should be updated with fall incident and should document a goal, intervention, and if any injuries were sustained it should be documented. Any orders obtained from the physician for treatment should also be documented.During a telephone interview on 08/15/2025 at 1: 50 PM The Director of Nursing #2 stated whoever completes the incident report is responsible to update the care plans. The risk for falls or actual fall care plans should be updated. The Director of Nursing #2 stated all residents should have a risk for fall care plan in place and then if they have a fall then it gets changed to actual fall care plan. All residents are at risk for fall so they should at a minimum have a risk for fall care plan in place on admission. The Director of Nursing #2 stated they and the Assistant Director of Nursing also go behind the staff to be sure the care plans are updated, and interventions are listed and implemented. it is weird that Resident #1 does not have a fall care plan. 2) Resident #2 admitted to the facility 01/29/2024 with diagnoses including but not limited to COVID-19, Dementia and Cerebral Infarction. A Modification of Admission/Medicare- 5-Day Minimum Data Set, dated [DATE] documented Resident #2 had a BIMS score of 11. The resident had impairment to their lower extremity on one side and used a wheelchair for locomotion. The resident required supervision for eating, moderate assistance for toileting, bed mobility and transfers. Resident #2 was at risk for pressure injuries but had no pressure injuries on admission. Review of a risk for pressure injury care plan initiated 02/9/2024 documented Resident #2 was at risk related to impaired mobility. Interventions listed included to inform the resident/family of any new areas of skin breakdown and monitor/document/report to Physician any changes in skin status.On Resident #2's risk for pressure injury there was no documented evidence of the presence of that Resident #2's of Resident #2's risk for pressure injury care plan was updated with the left heel eschar area identified on 02/11/2025. There was also no documented evidence of a actual pressure injury care plan being initiated.Review of Registered Nurse #3's progress note dated 02/11/2024 at 1:53 PM documented follow up for hard skin eschar to left heel, with staff nurse witness, Resident #2 was seen and assessed due to a history of eschar to the left heel, prior to assessment noted Resident #2 pointing to their heel float on top of the bed, gesture acknowledged. During the assessment Resident #2 was calm, no signs and symptoms of

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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** Based on record review and interviews during an abbreviated survey (NY00367889-591527, NY00367906-591522), 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 devices to prevent accidents for 1 of 3 residents (Resident #1) reviewed for safety and supervision. Specifically, on 01/01/2025 Resident #1 told Certified Nurse Aide #1 that they needed to get out of bed otherwise they were going to jump out. Certified Nurse Aide #1 left the resident alone in their room after the resident made the statement. When Certified Nurse Aide #1 returned to Resident #1's room, the resident was on the floor. Resident #1 sustained skin tears to both upper extremities.The findings are:The facility Safety and Supervision of Residents policy last reviewed 01/2024 documented the 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 resident risk factors. This facility follows current standards of practice to provide care and services designed to promote resident safety and minimize the risks of accidents.Resident #1 had diagnoses including but not limited to Polymyalgia Rheumatica, Asthma and Depression.An admission Minimum Data Set, dated [DATE] documented the resident had moderate cognitive impairment. The resident required a walker or a wheelchair for locomotion. The resident required set-up assistance with meals, moderate assistance with bed mobility and dependent for toileting, dressing and transfers.Review of a self-care care plan initiated 11/5/2024 documented Resident #1 required assistance with self-care and mobility related to limited mobility. Interventions listed included to encourage to participate to the fullest extent possible with each interaction, encourage to use bell to call for assistance, monitor skin for redness, open areas and cuts and report changes to the nurse.Review of a cognition care plan initiated 11/19/2024 documented Resident #1 had impaired cognition which might be impacted by their depression diagnosis. Interventions listed included monitor/document/report to nurse and medical provider any changes in cognitive function.Review of an accident/incident report dated 1/1/2025 documented Resident #1 had an unwitnessed fall, while caring for the resident Certified Nurse Aide #1 had to stop to respond to a code called in the facility. Certified Nurse Aide #1 lowered the bed and informed Resident #1 why they needed to leave. The resident threatened to jump out of the bed. Certified Nurse Aide #1 left the room to get assistance and upon return Resident #1 was observed on the floor of the room and sustained skin tears over their senile purpura as a result. Certified Nurse Aide #1 was educated to call for help by using the call bell or verbally calling out for help instead of leaving the room, especially if Resident #1 voiced that they will come out of the bed. The investigative summary concluded there was no evidence of intent or actual abuse, neglect, mistreatment towards the Resident.Review of Certified Nurse Aide #1's personnel file revealed they received individual education on fall safety precautions on 01/02/2025. The education documented when needing assistance from staff in cases of potential incidents or actual incidents do not leave the resident unattended use the call bell/or yell out for help.Attempt to reach Certified Nurse Aide #1 on 8/12/2025 and 8/15/2025 was unsuccessful.During a telephone interview on 08/15/2025 at 1: 50 PM, the Director of Nursing #2 stated they recall Resident #1 and some of the details from the incident that occurred on 01/01/2025 with Certified Nurse Aide #1.They stated Certified Nurse Aide #1 when interviewed, stated Resident #1 voiced to them that they were going to jump from the bed if left alone. The Director of Nursing #2 stated Certified Nurse Aide #1 left Resident #1's room and should not have left Resident #. They should have used the call bell to get help, especially if the resident threatened to jump out of the bed. 10 NYCFRR 415.12(h)(1)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews during an abbreviated survey (NY00338612/591526, NY00355525/591523) the facility did not ensure the environment was functional, sanitary, and comfortable for residents, staff, and the public. Specifically, on every unit in the facility there were multiple areas of chipped paint, scuff marks, visible dirt and stains on the walls and floors, base boards coming off the wall, wallpaper bubbling up and foul odors noted. The findings are:The facility Maintenance-Preventative policy last reviewed 5/2025 documented the facility provides preventative maintenance services to the facility, grounds, and equipment in accordance with current standards of practice and State and Federal Regulations. The Maintenance Director/designee will provide education to the maintenance staff upon hire and as needed regarding the provision of preventative maintenance tasks.During an interview on 6/13/2025 at 11:16 AM the Administrator stated they do environmental rounds two times daily with the Assistant Administrator in the morning and they also round in the afternoon. The Administrator stated if they see something that needs to be addressed, they inform the Director of Environmental/Housekeeping.During environmental rounds in the facility, with the Administrator and the Director of Environmental/Housekeeping, on 6/13/2025 from 11:40 AM to 12:34 PM the following were observed:6th floor Observation from 11:40 AM to 11:45 PM: Scuff marks were noted along the walls with visible dirt and debris. The plaster on the wall was chipped5th floor observation from 11:50 AM to 12 PM: Room # 504 was noted with chipped paint on the walls; Room # 521 noted with chipped paint on the door; Rm #526 noted with books and other materials all over the resident's room. There were crumbs noted all over the floor. There was mouse traps observed in the corners of the room. In Rm # 529- there was no shower head in the bathroom. Radiator covers were missing in the dining room.4th floor observation from12:02 PM to 12:08 PM the hallway floor and shower room had visible dirt and debris, the dining room and hallway floors were sticky; baseboards along the hallway were peeling off the wall and the wallpaper was bubbling up.3rd floor observation from 12:10 PM to 12:15: Metal panel along the hallway was missing screws.2nd floor observation from12:16 PM to 12:34 PM: foul odor noted at the end of the hallway by room [ROOM NUMBER]; a hole noted at the bottom of the wall in the bathroom.All areas observed discussed with the Administrator and the Director of Environmental/Housekeeping while rounding and they stated all areas would be addressed. During rounds, the Director of Environmental/Housekeeping stated the higher side rooms have not been renovated yet, but they will be completed soon. The Director of Environmental/Housekeeping stated that the scuff marks on the floors can be buffed out and they would assign staff to do this. The Director of Environmental/Housekeeping stated they think the stickiness on the floors is from the wax that they currently use, so they will investigate the product and possibly change products. During an interview on 6/13/2025 at 12:41 PM the Director of Environmental/Housekeeping stated they provide oversight to 15 housekeeping staff and 2 maintenance staff. The Director of Environmental/Housekeeping stated the housekeepers are given a daily cleaning list which includes deep cleaning of certain rooms. Deep cleanings are done one daily for a total of 5 rooms weekly. Deep cleaning also includes waxing and waxing is done in 3 rooms daily, 3 times a week until every room on the unit is done. The Director of Environmental/Housekeeping stated there is a maintenance book on each unit at the nurses' station where tasks can be requested. Staff can also text, call or inform the department by word of mouth if something is needed on a unit. Once a request is received, they report to the area to evaluate the job and the required equipment to complete the request. Time of completion is determined by the degree of repair needed. The Director of Environmental/Housekeeping stated they do have mice in the facility, but it is not a big issue and there are very few sightings, but enough to worry people. The Director of Environmental/Housekeeping stated the second floor, and the third floor are usually where the sightings are seen. The facility uses Allstate for pest control company, and they come to the facility every Tuesday and Thursday for service. The pest company is very diligent and once there is a reported sighting, and the company comes out there is very rarely a sighting after in the same area. Any issues reported are logged in a book, kept at the front desk. the pest company addresses issues the logbook first, then they make rounds in the kitchen, basement, outside the permitter and dining rooms. 10 NYCRR 415.29