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	02/12/2026

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** Based on record review and interviews during an abbreviated survey (2738206) the facility did not ensure that the Minimum Data Set accurately reflected the resident status for one (1) of three (3) residents (Resident #1) reviewed for general skin issues. Specifically, Resident #1 was admitted to the facility on [DATE] and the admission Minimum Data Set staged a wound on the sacrum as stage 2 (two) because it referenced the admission nurse's assessment. On 12/09/2025 the wound care provider assessed the wound as an unstageable wound, but the Minimum Data Set did not reflect this update. The 01/21/2026 Minimum Data Set has the sacral wound as a stage 4 (four).The policy titled MDS 3.0 last revised 8/2019, documented that the MDS 3.0 information will be completed by the Interdisciplinary Team (IDT). Each discipline will be responsible for completion of their sections and will follow the MDS Resident Assessment Instrument (RAI) manual guidelines. All disciplines that make entries on the MDS 3.0 are responsible to electronically sign and date. Resident #1 admitted on [DATE] had diagnoses that included Chronic Obstructive Pulmonary Disease (COPD - a term for lung and airway diseases that restrict your breathing), other Vasculitis (an inflammation of blood vessels) limited to the skin, and Cellulitis (bacterial infection affecting the deeper layers of the skin and underlying tissue) of unspecified part of limb.The admission Minimum Data Set, dated [DATE] with an assessment reference date of 12/15/2025 documented under Section M - skin conditions M0300, that Resident #1 had a stage two (2) pressure ulcer.The wound evaluation management summary dated 12/15/2025 documented on page 5 of 19 that Resident #1 had a wound on the sacrum that was identified as unstageable (due to necrosis). This document was electronically signed by the wound care provider on 12/22/2025 at 10:26 PM. A care plan with a focus as alteration in skin integrity documented that Resident #1 had an actual pressure injury related to (r/t): Sacral stage 4 (necrotic tissue) date initiated 12/09/2025. During an interview on 02/11/2026 at 10:40 AM with the Minimum Data Set Coordinator, they stated that they did not do the assessment for Resident #1, and that as the coordinator they mostly do administrative tasks. During this interview the Minimum Data Set Coordinator reviewed the wound notes for Resident #1 and noted that there was a 12/08/2025 assessment by the admission nurse that documented the wound as sacrum stage 2 (two), and they acknowledged that it was significantly different than the 12/09/2025 assessment by the wound care provider that documented the wound as sacrum unstageable. The Minimum Data Set Coordinator stated that the 12/09/2025 and the 12/15/2025 assessments by the wound care provider were not uploaded until 12/21/2025 and 12/22/2025 respectively, well after the Assessment Reference Date (ARD) 7 (seven) day look back period. The Minimum Data Set Coordinator stated that the 12/09/2025 and the 12/15/2025 assessments by the wound care provider should have been available, but since they were uploaded late the person that did the minimum data set assessment only had available the 12/08/2025 assessment by the admission nurse that documented the wound as sacrum stage 2 (two). NYCRR 415,11 (b)

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 (2738206) the facility did not ensure that residents received treatment and care in accordance with professional standards of practice for one (1) of three (3) residents (Resident #1) reviewed for general skin issues. Specifically, Resident #1 was admitted to the facility on [DATE] with three (3) different wounds in separate locations, the wound on their sacrum was assessed by the admission nurse as a stage two (2) pressure ulcer, but there were no orders in the electronic medical record for care or treatment until 12/12/2025.The policy titled Skin and Pressure Injury Prevention last reviewed 6/2024 documented that the purpose of the procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors. Under the heading risk assessment, it further documents that step one (1) is to assess the resident on admission/re-admission for existing pressure/injury risk factors utilizing the Braden Risk Assessment (an evidence-based tool for identifying residents at risk of developing pressure injuries), repeat the Braden Risk Assessment weekly for 4 weeks, quarterly, annually, or as often as is required based on the resident's clinical condition/progress. Resident #1 admitted on [DATE] had diagnoses that included Chronic Obstructive Pulmonary Disease (COPD - a term for lung and airway diseases that restrict your breathing), other Vasculitis (an inflammation of blood vessels) limited to the skin, and Cellulitis (bacterial infection affecting the deeper layers of the skin and underlying tissue) of unspecified part of limb.The admission Minimum Data Set, dated [DATE] with an assessment reference date of 12/15/2025 documented under Section M- skin conditions M0300, that Resident #1 had a stage two (2) pressure ulcer.The wound evaluation management summary dated 12/15/2025 documented on page 5 of 19 that there is a wound on the sacrum that was identified as unstageable (due to necrosis). This document was electronically signed by the wound care provider on 12/22/25 at 10:26 PM. A care plan with a focus of alteration in skin integrity documented that Resident #1 had an actual pressure injury related to (r/t): Sacral stage 4 (necrotic tissue) date initiated 12/09/2025. Medication (Phone) order dated 12/11/2025 with and end date 12/15/2025 documented Santyl External Ointment 250 UNIT/GM (Collagenase) apply to Sacrum topically every day shift for wound care. Cleanse area with Normal Saline pat dry, apply Santyl ointment to wound bed, then apply calcium alginate, and cover with DPD. During an interview on 02/11/2026 at 10:40 AM with the Minimum Data Set Coordinator, they stated that they did not do the assessment for Resident #1, and that as the coordinator they mostly do administrative tasks. During this interview the Minimum Data Set Coordinator reviewed the wound notes for Resident #1 and noted that there was a 12/08/2025 assessment by the admission nurse that documented the wound as sacrum stage 2 (two), and they acknowledged that it was significantly different than the 12/09/2025 assessment by the wound care provider that documented the wound as sacrum unstageable. The Minimum Data Set Coordinator stated that the 12/09/2025 and the 12/15/2025 assessments by the wound care provider were not uploaded until 12/21/2025 and 12/22/2025 respectively, well after the Assessment Reference Date (ARD) 7 (seven) day look back period. The Minimum Data Set Coordinator stated that the 12/09/2025 and the 12/15/2025 assessments by the wound care provider should have been available, but since they were uploaded late the person that did the minimum data set assessment only had available the 12/08/2025 assessment by the admission nurse that documented the wound as sacrum stage 2 (two). During an interview on 02/12/2026 at 4:21 PM Registered Nurse #8 stated that they were the Supervisor that was working on 12/11/2025 when it was brought to their attention by Certified Nurse Assistant #5 that Resident #1's sacral wound needed to receive treatment. Registered Nurse #8 stated that they called the on-call physician assistant (PA), they followed their (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	instructions and successfully placed a wound care treatment order in the Electronic Medical Record (EMR) to start the next day. Registered Nurse #8 stated that on 12/11/2025 they followed the wound care treatment order and performed a dressing change but did not write a note to document the treatment. NYCRR 415.12(c)(2)