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	01/12/2026

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

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews conducted during the recertification survey from 01/05/2026 to 01/12/2026, the facility did not ensure proper storage, preparation, distribution, and service of food in accordance with professional standards for food safety. Specifically, the kitchen refrigerators, freezers, spice/seasoning areas and dry storage areas contained food items that were expired, not labeled or dated with opened/prepared/expiration dates.The findings included: The facility policy titled Food Storage last revised 05/10/2024 documented: Sufficient storage facilities will be provided to keep foods safe, wholesome and appetizing. Food will be stored in an area that is clean, dry and free from contaminants. Refrigerator food storage: All foods should be covered, labeled and dated. All foods will be checked to assure that foods (including leftovers) will be consumed b their safe use-by dates, and frozen (where applicable) or discarded. Frozen foods: All foods should be covered, labeled and dated. All foods will be checked to assure that foods will be consumed by their safe use-by dates or discarded. During an initial kitchen observation of storage freezers, refrigerators, dry storage and seasoning area on 01/05/2026 at 9:32 AM with [NAME] Staff #1, Assistant [NAME] Staff #5, and Registered Dietician, the following was observed: Storage Freezers #1 and #2:-a six (6)-pound bag of [NAME] Brand plantains with half left in bag was observed with freezer burn, not dated when opened and did not have an expiration date.-a container of eight (8) cupcakes was observed with no date prepared or use by date.- a 4.69-pound package of goat meat was not labelled, was observed with freezer burn and did not contain a use by date. The package was labelled with a packed date of 10/12/2025.-An approximately 1 (one) pound bag of goat bones was observed in a plastic bag which was not properly sealed and had freezer burn. Seasoning area:-A five (5) pound container of Spur Tree brand curry powder was not labeled when opened and did not contain an expiration date.-An unlabeled five (5) pound container of a seasoning product was not dated when prepared and did not contain an expiration date.-A metal container containing [NAME] Moss was not labeled and did not contain a date prepared or expiration date.During an initial kitchen observation on 01/05/2025 at 09:32 AM of the produce refrigerator, dairy refrigerator, walk in freezer and dry storage area the following was observed:An approximately three (3) pound metal container of vanilla pudding that was not labeled and had a use by date of 12/26/2025. A metal container tray of shredded cabbage dated 01/03/2026 was not labeled and did not have a use by date.A metal tray of diced apples with an expiration date of 01/04/2026.A tray of diced apples was dated 02/19/2025. Dairy refrigerator: -A one-half block of yellow American cheese was not dated when opened and did not have a use by date.- A five-pound block of American cheese with approximately 3/4 remaining, was not sealed/closed. was not dated when opened and did not have a use by date.-an 11.29-pound block of cheddar cheese was not dated when opened. -a package of four (4) tortilla wraps was not labeled, did not have an expiration date and was not dated when opened.-A five (5) pound container of Cream O'Land Cottage Cheese with approximately 1/3 remaining was not dated when opened. -A five (5) pound bag of Parmesan Cheese was not dated when opened. Walk-in Freezer: -Approximately three (3) pounds of raw salmon was observed freezer burned and not labelled or dated. -Approximately two (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	(2) pounds of French Toast sticks were not labeled and were not dated when opened.-Four (4) toasted cheese sandwiches were not labeled or dated when prepared and did not have a use by date.-An approximately three (3) pound cooked beef product was not labelled, not dated when prepared, did not have a use by date and was observed with freezer burn. The product was wrapped in a cling wrap only. -An approximately one (1) pound cooked beef product was not labelled and did not have a date prepared or expiration date. -A 28-ounce bag of Garden Mills diced onions with approximately half remaining was not dated when opened and did not have an expiration date. The bag was observed opened and not sealed. Dry storage area:-A two (2) bag creamy rice product was not dated when opened.During interview and observation on 01/05/2026 at 9:36 AM [NAME] Staff #4 stated food items should be labeled, dated when opened and have a use by date before being placed in freezers/refrigerators. They stated to prevent freezer burn, food items should be properly stored in cling and freezer storage bags and not in hand tied plastic bags. During an interview and observation on 01/05/2026 at 9:36 AM, Assistant [NAME] #5 stated food items should be labeled, dated when opened and have a use by date before being placed in freezers/refrigerators. They stated foods should be disposed of if not used by the expiration date.During interviews on 01/06/206 at 4:40 PM and 01/09/2026 at 5:45 PM, the Director of Food Services stated they were aware of unlabeled, undated, expired and freezer-burn observations during initial tour of the facility kitchen. They stated food items should be labelled and dated when opened/prepared/expiration and properly sealed before being placed in the refrigerator/freezer. 10NYCRR 415.14(h)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations, interviews, and record review the facility did not ensure the resident's right to be treated with dignity and respect. This was evident for one (Resident #206) of five residents reviewed for Dignity. Specifically, Resident #206 was placed in common areas of the unit while wearing a hospital gown.The findings are:The policy titled Resident Rights dated 05/28/2024 documented residents have a basic right to a dignified existence.Resident #206 was admitted to the facility with diagnoses of bipolar disorder and schizoaffective disorder.The Social Work Note dated 01/05/2026 documented Resident #206 was cognitively impaired.On 01/05/2026 at 11:24 AM Resident #206 was observed wearing a hospital gown and using their left hand to grab the bottom of the gown to cover their genital area as they sat amongst four other residents in public view of anyone entering or leaving the unit. Resident #206 remained in the common area until 12:30 PM when a Certified Nurse Aide wheeled Resident #206's wheelchair in the dining room for lunch. There were seven residents eating lunch in the dining room and Resident #206 was placed at a table with a female resident seated across from them. Resident #206 continued to hold their hospital gown in place as they sat and ate lunch.On 01/12/2026 at 10:03 AM, the Unit Manager, Registered Nurse #11, was interviewed and stated Resident #206 was dressed in a hospital gown because they did not have any of their own clothing available to wear at the facility. They stated the facility's Concierge usually helped obtain donated clothing for new admissions, so they did not have to wear only a hospital gown, but the Concierge did not work over the weekend. They stated they did not obtain any donated clothing for Resident #206 prior to the resident being taken out of their room on 01/05/2026. Registered Nurse #11 stated, to respect their right to be treated with dignity, residents should not be placed in public view in only a hospital gown.On 01/12/2026 at 11:17 AM, the Director of Nursing was interviewed and stated residents in hospital gowns may be placed outside of their rooms in public view to promote safety and staff supervision. The Director of Nursing stated that a blanket or sheet could be used to promote the resident's dignity if the resident had nothing more to wear than a hospital gown.10 NYCRR 415.3(d)(1)(i)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility did not ensure each resident with a mental disorder was evaluated and received care and services in the most integrated setting appropriate to their needs for one (Resident #85) of three residents reviewed for Preadmission Screening and Resident Review. Specifically, Resident #85 was not referred for Level II specialized services once their facility stay was no longer brief or finite.The findings are:Resident #85 was admitted with diagnoses of attention deficit disorder, post-traumatic stress disorder, schizoaffective disorder, anxiety, and major depressive disorder.The Hospital Discharge summary dated [DATE] documented Resident #85 formerly lived at a group home with a ramp available to enter and had a rolling walker at home. The resident was in usual state of health besides a fall with facial injury caused by vertigo.The Patient Review Instrument dated 09/23/2025 documented Resident #85 required supervision with toileting and was chairfast or wheeled by someone else for mobility. Diagnoses included unspecified fall, anxiety, seizure disorder, schizoaffective disorder, dystonic tremor, and vertigo.The Preadmission Screening and Resident Review Level I screen dated 09/25/2025 documented Resident #85 had a home in the community to return to and had a serious mental illness. Resident #85 would be admitted to the facility for a very brief, finite stay.The Hospital Discharge Summary #2 dated 09/29/2025 documented Resident #85 required discharge to a rehabilitation facility due to facial injury and vertigo.The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #85 had a diagnosis of Post Traumatic Stress Disorder.The care plan related to short-term stay dated 10/01/2025 documented Resident #85 wanted to be asked about returning to the community on each assessment. Interventions included assist with discharge planning,The Social Work note dated 11/05/2025 documented the Social Worker called Resident #85's mother and was informed that the family was requesting the resident not return to the previous group home.There was no documented evidence Resident #85 was referred for Level II specialized services once their stay in the facility surpassed brief and finite.On 01/12/2026 at 10:09 AM, Registered Nurse #11 was interviewed and stated Resident #85 previously resided in a group home and was unable to be discharged to their former residence. Resident #85 did not receive physical therapy or any other skilled services and was mainly at the facility for medication management. Resident #85 did not require staff assistance with activities of daily living and ambulated independently throughout the unit without assistive devices. On 01/12/2026 at 2:38 PM, the Social Worker was interviewed and stated the Social Work Department was responsible for reviewing the Preadmission Screening and Resident Review information for new admissions and for long term residents that required Level II specialized services. The Social Worker stated Resident #85 should have been referred for Level II specialized services after it was determined they could no longer return to their former residence. The Social Worker stated they were only recently assigned Resident #85's case and the social worker that previously worked with Resident #85 no longer worked for the facility.10 NYCRR 415.11(e)

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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 observations, record review and interviews the facility did not ensure each resident received treatment and care in accordance with the professional standards of practice and the comprehensive person-centered care plan for one (1) of three (3) residents (Resident #108) reviewed for Skin Conditions. Specifically, 1.) wound care was not provided as per physician order for Resident #108. In addition, Licensed Practical Nurse #1 documented 01/05/2026 through 01/07/2026 administration of wound care that was not provided. The findings included:Resident #108's diagnoses included unspecified cellulitis, chronic venous insufficiency, and idiopathic gout.The quarterly Minimum Data Set, dated [DATE] documented Resident #108 was cognitively intact, had no rejection of cares, had no pressure ulcers or venous ulcers and had applications of ointments/medications other than to feet and no dressing applied to feet. A care plan dated 03/03/2025 documented Resident #108 had impaired skin integrity related to a venous wound of the right dorsal foot. Apply treatment as ordered. A physician order dated 12/12/2025 documented triamcinolone acetonide external cream 0.1%. Apply to right foot topically two (2) times a day and as needed for wound care treatment. Cleanse site with normal saline, pat dry, then apply triamcinolone ointment.During an observation and interview on 01/05/2026 at 12:15 PM, Resident #108 applied triamcinolone 0.1% gel topical to the right shin and dorsal foot area. Reddened open areas were on the dorsal right foot. Resident #108 stated they kept the wound care medication in their room and applied the medication to their right lower leg and foot a couple of times a day. They stated they received the topical medications from nursing staff. Resident#108 stated they had a history of cellulitis, and the wounds were cellulitis related. During an observation on 01/06/2026 at 8:53 AM Resident #108 had reddened open areas on the dorsal right foot. During an interview and observation on 01/07/2026 at 11:07 AM and 01/09/2026 at 9:42 AM one 15-gram tube of triamcinolone cream was on Resident #108's bed. Licensed Practical Nurse #1 stated they were aware that the medication was left in Resident #108's room. They stated Resident #108 liked to complete wound care treatments independently. They stated Resident #108 applied the prescribed treatment and cleansed the area. During a follow up interview and observation on 01/09/2026 at 9:42 AM, Licensed Practical Nurse #1 stated they did not apply or observe Resident #108 applying the triamcinolone ointment 01/05/2026 through 01/07/2026. They stated Resident #108 completed wound care independently during this time. They stated they documented completion of wound care on the electronic medical record during these dates. Licensed Practical Nurse #1 stated they were aware they should not have documented task completion if they did not actually complete wound care. During interviews and observations on 01/07/2026 at 11:56 AM and 01/09/2026 at 11:09 AM, Registered Nurse Unit Manager #2 stated they were not aware that Resident #108's topical medication was left in their room, and that Resident #108 completed wound care independently. They stated Resident #108 did not have a physician order or care plan to perform wound care independently. Registered Nurse Unit Manager #2 stated Licensed Practical Nurse #1 should not have documented they completed wound care if they did not actually complete it on 01/05/2026-01/07/2026. They stated Licensed Practical Nure #1 should have reported that Resident #108 completed their own wound care. They stated they would have contacted the Nurse Practitioner to assess Resident #108. 10 NYCRR 415.12

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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 observation, interview, and record review conducted during the Recertification Survey and Abbreviated survey (#2638932) on 01/05/2026 to 01/12/2026, the facility did not ensure the necessary treatment and services to promote healing and/or prevent new ulcers from developing for 3 of 3 residents (Resident #12, #8 and #169) reviewed for Pressure Ulcers. Specifically, for Resident # 12 with a left buttock stage two pressure ulcer, calcium alginate was not applied as per physician order, 2) for Resident #8 assessed at risk for pressure ulcers, heel offloading was not implemented as per care plan, and 3) for Resident #169 assessed at risk for pressure ulcers, heel offloading was not implemented as per care plan. Additionally, although offloading of Resident #8's heels was not observed on 01/05/2026 and 01/09/2026 the certified nurse aide tasks documented offloading had been provided. The findings include: The policy titled Skin and Pressure Injury Prevention, last revised 06/27/2024, documented: This facility will assess residents for risk in the development of pressure injuries and implement preventative measures in accordance with current standards of practice. The purpose is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors. Risk assessment included weekly skin monitoring by licensed nurse. Prevention measures included when in bed, every attempt should be made to off load pressure to heels (keep heels off the bed), placing a pillow from knee to ankle, heel boots or heel booties, and heel suspension boots/device. 1.Resident # 12 was admitted to the facility with diagnoses including but not limited to multiple sclerosis, paraplegia, acute respiratory distress. The admission Minimum Data Set (MDS; a resident assessment tool) dated 5/30/2025 documented Resident #12 had moderate cognitive impairment, was at risk for developing pressure ulcers, and had no pressure ulcers The 12/19/2025 physician order documented calcium alginate applied to the left buttock every day. The 12/25/2025 care plan titled Actual Pressure Injury Left Buttock Stage 2 documented monitor wound daily for signs of infection, monitor/document/report to physician as needed changes in skin appearance, color, wound healing, signs of infection, wound size and stage. The January 2026 Treatment Administration Record documented calcium alginate, apply to the left buttock topically daily. Cleanse area with normal saline, pat dry, apply calcium alginate, then cover with a dry protective dressing. During observation on 01/07/2026 at 11:04 AM, Resident #12 was positioned on their right side for treatment administration to the left buttock. Registered Nurse # 13 applied zinc oxide to the left buttock. During interview on 01/08/2026 at 12:29 PM the Wound Care Nurse stated Resident #12 had a physician order for calcium alginate to the left buttock stage 2 pressure ulcer. During interview on 01/08/2026 at 3:09 PM Registered Nurse # 13 stated that although they saw the calcium alginate order for the left buttock, they applied zinc oxide instead. They stated zinc oxide (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was used as a skin protectant. 2) Resident #8 had diagnoses including acute osteomyelitis, left ankle and foot acquired absence of other left toes, and cellulitis of the left lower limb. The quarterly Minimum Data Set, dated [DATE] documented Resident #8 had severe cognitive impairment, bilateral lower extremity impairment, was dependent on staff for bed mobility and transfers, had one (1) stage two pressure ulcer present on admission and was at risk for pressure ulcers. The care plan titled Risk for Pressure Ulcers dated 07/22/2022 documented heel protection, offload heels with pillows or boots as tolerated. During on observation on 01/05/2026 at 1:15 PM, 01/07/2026 at 9:10 AM, and 01/09/2026 at 8:54 AM and 10:06 AM Resident #8 was sleeping in bed on their back. Both heels rested on the mattress. There were no pillows or boots to provide offloading. During an observation and interview on 01/09/2026 at 10:08 AM, Certified Nurse Aide #17 stated Resident #8's heels were resting on the mattress and not offloaded. They stated they provided cares for Resident #8 at approximately 6:45 AM on 01/05/2026 and 01/09/2026 and forgot to apply heel boots. Certified Nurse Aide #17 stated the certified nurse tasks documented Resident #8's heels were to be offloaded with pillows or boots as tolerated. Certified Nurse Aide #17 stated although they documented Resident #8's heels were offloaded with pillows or boots on 01/05/2026 at 8:12 AM and 01/09/2026 at 8:08 AM they did not complete the task. During an interview on 01/09/2026 10:40 AM, Licensed Practical Nurse #8 stated Resident #8 was at risk for pressure ulcers, and both heels should be offloaded with pillows or booties. They stated they have observed Resident #8's heels not offloaded with pillows or boots in the past. Licensed Practical Nurse #8 stated when they observed Resident #8's heels not offloaded they would offload them and remind certified nurse aide/s that the resident's heels should be offloaded. During an interview on 01/09/2026 at 10:47 AM, Registered Nurse Unit Manager #2 stated Resident #8's heels should be offloaded except during cares. They stated staff did not report concerns regarding offloading Resident #8's heels or that Resident #8 rejected offloading of the heels. They stated they completed rounds daily but did not always remove sheets to check if offloading was completed. They stated staff should not document completion of tasks if they did not complete the task. 3) Resident #169 diagnoses included hemiplegia and hemiparesis following non-traumatic intracerebral hemorrhage affecting left non-dominant side. The quarterly Minimum Data Set, dated [DATE] documented Resident #169 had severe cognitive impairment, no rejection of cares, was dependent on staff with bed mobility and was at risk for pressure ulcers. The current care plan titled Risk for Pressure Ulcers documented heels offloaded with pillows or boots as tolerated. The current certified nurse aide Kardex tasks documented heels offloaded with pillows or boots as (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tolerated. During observation on 01/05/2026 at 1:23 PM, 01/05/2026 at 5:10 PM, 01/06/2026 at 9:13 AM, 01/07/2026 at 9:05 AM, and 01/07/2026 at 3:11 PM, Resident #169 was in bed with both heels resting on the mattress. There were no pillows or boots to provide offloading. During an interview and observation on 01/07/2026 3:56 PM, Certified Nurse Aide #18 stated Resident #169's heels were not offloaded. They stated they could not recall if Resident #169's heels should be offloaded or if the directive to offload heels was included on the certified nurse aide Kardex. They stated they were not aware when they last offloaded Resident #169's heels. During an interview and observation on 01/07/2026 at 4:03 PM, Registered Nurse Unit Manager #2 stated Resident #169's heels were on the mattress, not offloaded and the resident had no booties in place. Registered Nurse Unit Manager #2 stated they and unit nurses were responsible for oversight of certified nurse aide task completion. Registered Nurse Unit Manager #2 s stated as per care plan intervention and certified nurse aide Kardex Resident #169's heels should be offloaded. They stated staff did not report Resident #169's heels were not offloaded or that there were no booties in the resident's room. During an interview on 01/08/2026 at 10:20 AM, Certified Nurse Aide #9 stated they did not apply booties or offload heels with pillows for Resident #169 on Monday 1/5/2025 or 01/07/2025. They stated there were no booties present in Resident #169's room and they had not used pillows to offload the resident's heels in a while. During an interview on 01/08/2026 at 11:51 AM Licensed Practical Nurse #8 stated they could not recall if Resident #169 had a physician order or care plan intervention for heel offloading or booties. They stated they did not recall observation of Resident #169 with booties or offloaded heels. They stated residents who were primarily bed bound should have heels offloaded. 10NYCRR 415.12(c)(1)

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review conducted during the Recertification and Abbreviated Survey (#2638932), the facility did not ensure each resident received necessary respiratory care in accordance with professional standards of practice for two (2) of three (3) residents (Resident #12 and Resident #149) reviewed for Respiratory Care. Specifically, 1. Resident # 12 did not receive the correct oxygen flow rate of 6 liters per minute as per physician order and 2. Resident #149 did not receive the correct oxygen flow rate of 3 liters per minute as per physician order.The findings include The policy titled Oxygen Therapy Administration reviewed 9/2025 documented oxygen therapy is administered by licensed nurses or respiratory therapists in accordance with healthcare provider orders and in accordance with the state scope of practice and nurse practice act. Method of oxygen delivery includes oxygen concentrator often used for residents who require low flow oxygen on a regular basis. Oxygen delivery system include Venturi (Venti) Mask designed to deliver a specific concentration of oxygen (e.g., 24%, 28%, 31%, 35%, 40%, 50%, etc.) 1.Resident # 12 was admitted with diagnoses including but not limited to acute respiratory failure, multiple sclerosis and paraplegia. The 5/27/25 care plan titled Alteration in Respiratory System documented provide oxygen as per physician's orders. The 5/29/2025 physician order documented continuous oxygen at 6 Liters per minute and 35% humidification via tracheostomy. The 10/5/2025 Quarterly Minimum Data Set (an assessment tool) documented Resident #12 was cognitively intact, received oxygen, suctioning, and tracheostomy care. During observation on 01/05/2026 at 9:46 AM Resident #12 was in bed with the head of bed elevated at 30 degrees. Resident #12 was awake and had a tracheostomy. The bedside oxygen concentrator was set at 10 liters per minute. The oxygen was being administered via tracheostomy. During observation on 01/06/2026 at 1:06 PM Resident #12's bedside oxygen concentrator was set at 10 liters per minute. The oxygen was being administered via tracheostomy. During observation and interview on 01/07/2026 at 3:27PM, Resident #12 was observed in the hallway sitting in a wheelchair. Oxygen was being administered via tracheostomy at 8 liters per minute. Registered Nurse Unit Manager #14 checked the oxygen flow rate and stated it was being administered at 8 liters per minute. Registered Nurse Unit Manager #14 stated the resident was not receiving the correct oxygen amount per the physician order. Registered Nurse Unit Manager #14 stated it was their responsibility to ensure Resident #12 received the oxygen as per physician order. During interview on 01/12/2026 at 1:18 PM, the Medical Director stated the nurses should check the physician order to make sure residents receive the correct amount of oxygen. 2. Resident #149 had diagnoses including chronic pulmonary obstructive disease, Type II diabetes mellitus and history of chronic respiratory failure with hypoxia. (continued on next page)

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	01/12/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The care plan titled Alteration in Respiratory System last revised 07/09/2025 documented administer treatments and medications as per physician orders. The physician order dated 12/29/23 documented supplemental oxygen via nasal cannula at three (3) liters/minute to maintain oxygen status. The quarterly Minimum Data Set (a resident assessment tool) dated 11/16/2025 documented Resident #149 was cognitively intact, had no shortness of breath, and received oxygen therapy. During an observation on 01/05/2026 at 11:57 AM, 01/05/2026 at 1:54 PM, and 01/06/2026 at 9:35 AM Resident #149 was ambulating in the hall. Oxygen was being administered via nasal cannula at two (2) liters per minute. During an observation on 01/07/2026 at 9:20 AM Resident #149 was seated in the dining room. Oxygen was being administered at two (2) liters per minute via nasal cannula. During an interview on 01/06/2026 at 9:42 AM Resident #149 stated they changed the oxygen administration flow rate on their portable tank independently from three (3) liters to two (2) liters. They stated they did not discuss changing the oxygen flow rate with the staff. During an interview on 01/08/2026 at 10:33 AM, Certified Nurse Aide #9 stated they observed Resident #149 adjusting the oxygen level dials on the tank frequently but did not report this to the nurses. During an interview on 01/08/2026 at 11:28 AM, Licensed Practical Nurse #8 stated they checked the oxygen administration rate during medication rounds and throughout the shift. Licensed Practical Nurse #8 stated Resident #149 had a physician order for oxygen at two (3) liters/minute. They stated they were aware Resident #149 changed the oxygen flow rate to two (2) liters/minute. They stated Resident #149 was educated on the importance of not adjusting the oxygen flow rate. Licensed Practical Nurse #8 stated they requested Resident #149 to report any oxygen flow rate concerns. They stated they verbally discussed Resident #149 changing the oxygen flow rate with the physician but were not sure if it was documented in the electronic medical record. During an interview on 01/09/2026 at 11:18 AM, Registered Nurse Unit Manager #2 stated they were not aware that Resident #149 changed the oxygen flow rate. They stated unit staff should have immediately reported the concern. NYCRR415.12 (k) (6)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review conducted during the recertification survey from the facility did not ensure that drugs and biologicals were maintained in accordance with current professional standards for storage, labeling and expiration dates. Specifically, 1. observation of the fifth-floor medication cart revealed an insulin pen with no open date or discard date, and 2. one 15-gram tube of triamcinolone cream 0.1%, and one tube of diclofenac gel 1% were on the bedside table in Resident 108's room. The findings include: The policy titled Medication Administration dated 12/2019 documented the expiration date on the medication label must be checked prior to administering. When opening a multi dose container, the date shall be recorded on the container. The policy titled Insulin Administration dated 1/2020 documented check the expiration date, if opening a new vial, record the expiration date and time on the vial (follow manufacturers recommendations for expiration after opening). 1.The physician order dated 09/18/2024 documented Insulin Glargine Subcutaneous Solution Pen-Injector (Insulin Glargine) inject 38 units subcutaneously twice a day for Type 2 Diabetes Mellitus. Resident # 144 admitted with a diagnosis of Type 2 Diabetes Mellitus, chronic systolic heart failure and end stage renal disease. The quarterly minimum data set (an assessment tool) dated 10/28/2025 documented Resident #144 received seven insulin injections out of seven days observed. During an observation of the fifth-floor medication cart on 01/05/2026 at 3:40 PM a Lantus Solostar insulin Pen was found with no open or discard date written on the label for Resident #144. During an interview on 01/05/2026 at 3:41 PM, Licensed Practical Nurse # 10 stated whoever opened the insulin pen did not date it. They stated when the insulin pen was opened it was supposed to be dated. They stated the insulin pen was last administered on 01/05/2026 at 8:51 AM. Additionally, they stated the insulin pen was good for 28 days after opened. During an interview on 01/05/2026 at 4:02 PM, Registered Nurse Unit Manager #11 stated the registered nurse was responsible for labeling the insulin pen when received from the pharmacy. They stated they did not know why the insulin pen was not dated properly. During an interview on 01/12/2026 at 12:15 PM the Director of Nursing stated they did not know why there was no date on the insulin pen. They stated that they, the nursing educator and the nursing supervisors were responsible for educating the staff regarding proper labeling of insulin pens. 2) Resident #108's diagnoses included unspecified cellulitis, chronic venous insufficiency, and idiopathic gout. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The quarterly Minimum Data Set, dated [DATE] documented Resident #108 was cognitively intact. During an observation on 01/05/2026 at 12:15 PM, a tube of diclofenac sodium topical gel 10% was observed on Resident's bed. There was no staff present in Resident 108's room during observation. Resident #108 stated they kept the medications in their room. They stated they received the topical medication from nursing staff. During an observation on 01/06/2026 at 8:53 AM, a tube of diclofenac sodium topical gel 10% and a tube of triamcinolone 0.1% topical gel was observed in a round basin on top of the bedside table in Resident #108's room. There was no staff present in Resident #108's room. Resident #108 stated they stored the medications in their room. During an interview and observation on 01/07/2026 at 11:07 AM and 01/09/2026 at 9:42 AM, one 15-gram tube of triamcinolone cream 0.1%, and one tube of diclofenac gel 1% were on Resident #108's bed. Licensed Practical Nurse #1 stated they were aware the medications were left in Resident #108's room. They stated Resident #108 liked to apply their skin care medications. They stated they were aware that medication should not be left in a resident room. During interviews on 01/07/2026 11:56 AM and 01/09/2026 11:09 AM Registered Nurse Unit Manager #2 stated they were not aware that Resident 108's topical medications were left in Resident #108's room. NYCRR 415.18(d)