STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335459	A. Building B. Wing	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westchester Center for Rehabilitation & Nursing	10 Claremont Ave Mount Vernon, NY 10550

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on record review and interviews during the Recertification and Abbreviated (NY#00336657) surveys from 1/22/2025 to 1/29/2025, the facility did not ensure a resident's designated representative had the right to be informed in advance, by the physician or other practitioner or professional, of treatment options and to choose the alternative or option they preferred for 1 (Resident # 233) of 2 residents reviewed for resident rights. Specifically, the facility administered Donepezil (a medication for dementia) to Resident #233 and the resident representative had requested the medication to not be given. Findings include: Resident # 233 was admitted with diagnoses including dementia, chronic obstructive pulmonary disease and gastroesophageal reflux disease. The facility's policy and procedure titled Resident Rights, revised 11/2024, documented the resident rights to be notified of his or her medical condition and of any changes in his or her condition; A resident has the right to be informed in advance, by the physician or other Practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option they prefer. The 7/24/2023 care plan, updated on 8/22/2023, documented the resident had Cognitive Loss/Dementia and the goal was Resident #233 would remain at their current level of cognitive functioning. Interventions included to communicate with the resident, family and staff regarding the resident's capabilities and needs. The 8/1/2023 Minimum Data Set (an assessment tool) documented the resident had severe cognitive impairment. The 02/23/2024 Neurology consult documented the reason for the consult was Alzheimer's disease with a recommendation to consider a trial of Donepezil 5 milligrams at bedtime for cognitive support. The 02/23/2024 Physician progress note documented the resident was seen by the neurologist, and they agreed with the neurology consult. The plan was to consider a trial of Donepezil 5 milligrams for cognitive support for Alzheimer's disease. The 02/23/2024 Physician order documented to administer Donepezil 5 milligrams tablet, give 2 tablets once daily in the evening at 6:00 PM for Alzheimer's disease. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 02/23/2024 at 4:02 PM nursing progress note documented Resident #233 was seen and assessed by the Neurologist and the Neurologist recommended to a consider trial of Donepezil 5 milligram at bedtime daily for cognitive support. The Attending Physician was contacted and in agreement with the plan of care. The resident representative was called and educated on the recommended medication and verbalized they did not want the medication given to the resident yet. The physician was made aware, and no new orders were given. The 02/26/24 at 7:52 nursing progress note documented resident's resident representative was contacted and asked if they agreed with the Neurologist recommendation for Donepezil and verbalized, they wanted more time to decide. The physician was made aware, and no new orders were given. The Medication Administration Record documented Resident #233 received Donepezil 5 milligram tablet daily from 02/28/2024 to 03/17/ 2024. The 3/11/2024 Physician progress note documented Resident #233 was seen and examined for monthly evaluation and medications included Donepezil 5 milligram tablet. The 3/18/2024 Nurse Practitioner progress note documented they reviewed medications with resident representative, and they declined the medication Donepezil. This was discussed with the Physician and nursing and Donepezil was discontinued. When interviewed on 1/28/2025 at 4:19 PM, the Director of Nursing stated the facility protocol was to notify the family designated representative of any changes in medications. When interviewed on 1/29/2025 at 9:54 AM, the Nurse Practitioner stated they spoke with the resident representative on 3/18/2025 review the medications and they requested the Donepezil to be discontinued. The Nurse Practitioner stated the medication should have been discontinued when resident's representative did not want it given. When interviewed on 1/29/2025 at 6:41 PM, the Director of Nursing stated they did not know why the Donepezil medication was administered. 415.3(c)(1)(iii)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review conducted during the recertification and abbreviated (NY00352407) from 1/22/2025 to 1/29/2025, the facility did not ensure a resident's right to receive written notice, including the reason for the change, before the resident's room was changed. This was evident for 1 (Resident #10) of 7 residents reviewed for Choices. Specifically, Resident #10's Health Care Agent did not receive written notice of or explanation for the resident's room change on 10/11/2024. The findings are: The facility policy titled Transfers - Room Changes dated 4/11/2024 documented the facility will inform the resident and/or resident representative of the room change both verbally and written, including the reason for the change, the effective date of the change and the location of the change. Resident #10 had diagnoses of Alzheimer's disease and cerebral infarction with right hemiplegia and hemiparesis. Minimum Data Set 3.0 assessment dated [DATE] documented Resident #10 was severely cognitively impaired. Census Activity dated 10/11/2024 documented Resident #10 had a room change. Social Work Note dated 10/11/2024 documented Resident #10's room was changed due to medical necessity and a message was left for the resident's Health Care Agent. There was no documented evidence Resident #10's Health Care Agent was provided written notice and explanation for the resident's room change on 10/11/2024. On 1/22/2025 at 12:54 PM, Resident #10's Health Care Agent was interviewed and stated Resident #10's room was changed, and they were not provided with an opportunity to refuse the room change, given prior notification of the room change, or given a reason for the room change. \On 1/29/2025 at 12:03 PM, the Director of Social Work was interviewed and stated Resident #10 was moved due to medical necessity and a voicemail was left for the Health Care Agent. The Director of Social Work did not confirm whether the Resident #10's Health Care Agent received the voicemail or agreed with the room change prior to moving the resident to another room. On 1/29/2025 at 3:51 PM, the Administrator was interviewed and stated residents and families were informed prior to a room change occurring due to another resident's medical necessity. 10 NYCRR 415.3(g)(3)

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review conducted during the recertification and abbreviated (NY00344201) from 1/22/2025 to 1/29/2025, the facility did not ensure a resident's right to manage their financial affairs. This was evident for 1 (Resident #182) of 3 residents during Personal Funds review. Specifically, the facility diverted Resident #182's income to a personal needs account managed by the facility without informing the resident's court-appointed Legal Guardian. The findings are: The facility policy titled Resident Rights dated 11/2024 documented residents had the right to manage their personal funds. Resident #182 had diagnoses of unspecified dementia and schizoaffectove disorder. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #182 was severely cognitively impaired, the resident and their family participated in the assessment, the resident's family provided discharge status information, and did not document that Resident #182 had a Legal Guardian. The admission Agreement dated 10/26/2022 documented the undersigned agreed to pay the net available monthly income for Resident #182, a Medicaid recipient, to the facility by the 6th day of each month or to arrange for the income payor to send the monthly income directly to the facility. The admission Agreement was signed by Resident #182's Legal Guardian. Addendum VI of the admission Agreement documented the undersigned would agree to arrange for direct payment of the resident's monthly income to the facility. There was no documented evidence Resident #182's Legal Guardian signed Addendum VI or agreed with changing Resident #182's income recipient or address. A Supreme Court Oath and Designation dated 4/14/2023 documented the appointment of Resident #182's Legal Guardian as the guardian of the resident's person and property. The Comprehensive Care Plan related to Advance Directives initiated 11/1/2022 was updated by the Director of Social Work on 5/24/2024 and documented Resident #182's Legal Guardian provided documentation the court appointed them Legal Guardian of Resident #182's person and property. The Aspen Complaint Tracking System Intake dated 6/4/2024 documented an allegation the facility changed Resident #182's income recipient without notifying the resident's Legal Guardian. The facility's Accounts Receivable Ledger for Resident #182 documented net available monthly income credits to Resident #182's account on 6/11/2024, 7/1/2024, and 8/6/2024. The facility's Resident Funds Ledger documented $50 personal needs allowance credits to Resident #182's account on 6/11/2024, 7/1/2024, and 8/6/2024. A Social Security Administration notification addressed to the facility on 8/26/2024 documented the facility was removed as Resident #182's representative payee and would no longer receive the resident's monthly income. (continued on next page)

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documented evidence the facility obtained written authorization from Resident #182's Legal Guardian prior to depositing income with the facility and opening a personal needs account for the resident. On 1/29/2025 at 12:03 PM, the Director of Social Work was interviewed and stated they received a copy of court documents from Resident #182's Legal Guardian in 5/2024 and updated the resident's medical record to reflect Resident #182 had a court-appointed indicate the court appointed Legal Guardian of person and property. On 1/29/2025 at 11:16 AM and 5:42 PM, the Fiscal Manager was interviewed and stated they were responsible for overseeing resident funds accounts. After reviewing Resident #182's deposits in 6/2024, 7/2024, and 8/2024, the Fiscal Manager stated the Business Office applied to become the representative payee (recipient) of Resident #182's monthly income check in 6/2024 upon Medicaid approval and determination of the resident's net available monthly income amount to be paid to the facility. Resident #182 was cognitively impaired and unable to participate in financial discussions or decisions. The Fiscal Manager stated they were not aware Resident #182 had a Legal Guardian responsible for financial decisions until 9/2024 when they received a notification from the Social Security Administration informing the facility they were no longer representative payee for the resident. The Fiscal Manager stated they did not attempt to contact any next of kin listed on Resident #182's facesheet and did not have any communication with the resident's Legal Guardian prior to or after the facility became representative payee for the resident. On 1/29/2025 at 4:15 PM, the Administrator was interviewed and stated they were not aware of any financial concerns related to Resident #182's net available monthly income or personal funds account with the facility. 10 NYCRR 415.26(h)(5)

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review during the recertification survey from 1/22-1/29/2025, the facility did not ensure that residents' financial records were available to the residents through quarterly statements for 1 of 4 residents reviewed for personal funds. Specifically, Resident #92 was not aware that they had any personal funds and the facility financial office was not able to provide proof that the resident received quarterly statements. Findings include: Facility Policy titled Resident's Funds last reviewed 10/2024 documented 24/7 access to funds, maintaining and managing resident accounts, and process for accessing funds. It did not document a process for providing residents with quarterly statements. Resident #92 had diagnoses including Diabetes Mellitus, End Stage Renal Disease, and Non-Alzheimer's Dementia. The Quarterly Minimum Data Set, dated [DATE] documented the resident had moderately impaired cognition, and the resident and family participated in goal setting. During an interview on 1/23/25 at 9:47AM, Resident #92 denied having any money or receiving any financial statements. On 01/23/25 at 4:00PM Resident #92's Fund Ledger for 1/1/24-12/31/24 was provided for review. It was documented that Resident #92's funds were managed by the facility and funds were in their account. During an interview on 1/29/25 at 10:36 AM, the Fiscal Manager stated they handled resident personal fund accounts and residents that were alert and oriented were hand delivered quarterly statements. They stated Resident #92 received quarterly statements, but they were unable to provide documented evidence that the statements were received. They stated they save the quarterly batch of statements that were distributed to residents on their computer, but they could not provide evidence of who received their statements. They stated Resident #92 had not inquired about money or statements, and they did not recall them coming for funds during banking hours. According to their financial statement, Resident #92 received services for the barber, but they did not have to request those funds as they were automatically deducted from their account to cover the expense. The Fiscal Manager was uncertain if Resident #92 was aware that they were paying for those services out of their personal funds. Stated that they would follow up with Resident #92 to ensure that they were aware of their funds and review their statement with them. 10NYCRR415.26(h)(5)(i)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews conducted during the Recertification survey from 01/22/2025 to 01/27/2025, the facility did not ensure that 3(Residents #226, #333, and #96) of 3 Residents reviewed for Respiratory Care was provided with such care, consistent with the professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Specifically, 1. Resident #226 who had a Physicians order for Oxygen to be administered via nasal cannula at 2 liters per minute, was observed multiple times with the Oxygen rate not consistent with the Physicians' order, and with the tubing disconnected from the Oxygen concentrator. 2. Resident #333 who had a Physicians orders for Oxygen to be administered via nasal cannula at 2 liters per minute, was observed multiple times with the Oxygen rate not consistent with the Physicians' order, and the facility did not address the Ear, Nose, and Throat recommendations to give Resident #333 humidified oxygen until 2 days after return from the appointment. 3. Resident #96 had a Physicians' order to change the oxygen cannula and filter weekly, label and date the tubing weekly, and there were multiple observations of the Physicians' orders not being followed. The findings are: The facility policy titled Oxygen Administration last revised on 6/2023 documented that Oxygen therapy will be administered by Licensed Nurses with a Physician's Order to provide a resident with sufficient oxygen to their blood and tissues. Oxygen equipment will be checked daily for correct flow and concentration and correct set-up of equipment. 1. Resident #226 was admitted on [DATE] with diagnoses including asthma, hypertension, and hyperlipidemia. The 12/23/24 admission Assessment Minimum Data Set documented Resident #226 had severely impaired cognition, had a diagnosis of asthma, and received continuous oxygen therapy. The 12/17/24 Physician order documented Resident #226 was to receive continuous Oxygen Via a Nasal Cannula Rate at 2 liters per minute. The Ineffective Airway Clearance/Oxygen Care Plan date 1/20/25 documented that Resident #226 was to receive Breathing Oxygen therapy at 2 Liters per minute via nasal cannula. Interventions included to monitor oxygen saturation. On 1/22/25 at 2:09 PM, Resident #226 was observed in bed on Oxygen via nasal cannula set to 3.5 liters per minute. On 1/23/25 at 9:58 AM, Resident #226 was observed in bed with oxygen at 3 liters per minute and oxygen tube was disconnected from the concentrator. On 1/23/25 at 10:17 AM, Resident #226 was observed in bed on Oxygen via nasal cannula set to 3 liters per minute, tubing was on the floor and not connected to the concentrator. Resident #226 was observed to be breathing deep and gargling. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/23/25 at 10:19 AM, Registered Nurse #2 stated nurses were responsible for ensuring the oxygen was connected to the resident and the concentrator, functioning properly, and the oxygen flow rate was set as per Physician order. Registered Nurse #2 stated the oxygen tubing should not be on floor, and that it should be connected to the concentrator and the resident. Registered Nurse #2 went and got fresh tubing, connecting the tubing to Resident #226 and the concentrator, lowered the flow rate from 3 liters per minute to 2 liters per minutes, and applied the pulse oximeter to Resident #226's finger. When first applied, the Oxygen saturation level started at 89%, and gradually went up to 94% on 2 liters per minute. During an interview on 1/29/25 at 9:33 AM, the Director of Nursing stated that nurses should have been doing rounds and to ensure that oxygen was plugged in and functioning. They stated nurses should have checked to see if the oxygen tubing was connected to the concentrator and administered as per physician order. 2. Resident #333 was admitted on [DATE] with diagnoses including heart failure, peripheral vascular disease, and chronic kidney disease. The 1/23/25 admission Minimum Date Set documented Resident #333 had intact cognition and was receiving continuous Oxygen therapy. The 1/22/25 Physician orders documented Resident #333 was to receive continuous Oxygen via nasal cannula rate at 2 liters per minute every day and on every shift, and hold 1/24/25-1/26/25. The 1/24/25 Physician order documented Resident #333 was to receive a trial of continuous Oxygen via nasal cannula 1.5 liters per minute, every day, on every shift for 2 days. On 1/22/25 at 10:46 AM, Resident #333 was observed in bed on oxygen set at 3 liters per minute via nasal cannula. When interviewed during the observation, Resident #333 stated they needed oxygen to breathe. On 1/24/25 at 9:35 AM , Resident #333 was observed in bed and Oxygen was at 3L/min via nasal cannula. During an interview on 1/24/25 at 9:45 AM, Registered Nurse #4 stated Resident #333's Oxygen was set to 3 liters per minute and should have been set at 2 liters per minute. They stated they did rounds and did not check Resident #333's oxygen and assumed it was set to the appropriate rate. Registered Nurse #4 stated they were responsible for ensuring that the oxygen was set at the correct rate, and they signed for the oxygen and confirmed via Physician orders in the Electronic Health Record that it should have been set to 2 liters per minute. During an interview on 1/24/25 at 9:49 AM, License Practical Nurse Unit Manager #3 stated nurses signed off on oxygen, and were responsible for ensuring the resident was receiving the physician ordered rate. On 1/27/25 at 8:50 AM, Resident #333 was observed with oxygen set at 3 liters per minute via nasal cannula. License Practical Nurse Unit Manager #3 stated the Oxygen rate should have not been set to 3 liters per minute. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Ear, Nose and Throat(ENT) consult for Resident #333, dated 1/27/25, documented recommendations to administer saline mist 3-4 drops x 1, humidification for oxygen, and to follow up in 3-4 weeks. The 1/27/2025 at 4:17 PM nursing progress note by Licensed Practical Nurse Unit Manager #3 documented Resident #333 returned from their appointment with the Ear, Nose, and Throat, and the recommendations were for Resident #333 to receive a Humidifier for Oxygen. The Physician was notified and in agreement with orders, and all orders were entered into Electronic Health Records. On 1/28/25 at 1:49 PM, Resident #333 was observed on oxygen set to 3 liters per minute and had no humidifier. During an interview on 01/28/25 at 1:49 PM, Resident #333's family member stated they requested the Resident to receive an updated oxygen concentrator with a humidifier, and Resident #333 did not receive one. During an interview 1/29/25 at 8:58 AM, Registered Nurse Unit Manager #5 stated Resident #333 went to an outside appointment the Ear, Nose, and Throat(ENT) doctor, and they recommended a humidifier and stated that Resident #333 had not received one as the facility did not have any available. During an interview on 1/29/25 at 9:26 AM, the Director of Nursing stated the nurses were responsible for doing rounds and checking residents on oxygen looking at equipment and the flow rate. The Director of Nursing stated the facility had humidifiers available and Resident #333 should have received one immediately upon return as per Ear, Nose and Throat doctor's recommendation. During an interview on 01/29/25 at 12:32 PM, Medical Doctor #1 stated they were not notified Resident #333 had recommendations from Ear, Nose and Throat doctor from their appointment on 1/27/25 and that they were informed on 1/29/25. Medical Doctor #1 stated that when a resident returned from an outside doctor's appointment with recommendations on the consult, they expected to be immediately notified. Medical Doctor #1 stated Resident #333 could benefit from humidified oxygen due to history of nose bleeds. Medical Doctor #1 stated that Resident #333's family member requested to bring in a humidifier, but maintenance denied it because they did not allow outside electrical equipment. Medical Doctor #1 stated they would order a humidifier as it would help with the resident's breathing and their nosebleeds. 10 NYCRR 415.12

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews conducted during the Recertification and Abbreviated surveys (NY00337247)) from 01/22/25 to 01/29/25, the facility did not ensure that there was sufficient nursing staff to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically, 1. Upon review of the nursing staffing schedule from 12/22/24-1/29/25, for multiple days, on all three shifts of staffing for each unit, the facility did not provide adequate staffing to meet the needs of the residents, and as per their Facility Assessment, 2. On multiple dates during the night shift on the 2 South Unit, there were only two Certified Nurse Aides scheduled which was not consistent with the Facility assessment that documented that there should be a minimum of three certified nurse aides. Also, on multiple dates during the day shift on the 2 South Unit, there were only three Certified Nurse Aides scheduled which was not consistent with the Facility assessment that documented that there should be a minimum of four Certified Nurse Aides 3. On, 1/23/25 during the Resident Council meeting, multiple residents verbalized concerns about staffing, the number of call outs and floating Certified Nurse Aides, and how the units are staffed below minimum with certified nurse aides. The findings are: The facility policy titled Sufficient Staffing last revised on 7/1/23 documented that the facility will provide sufficient staffing to meet needed care and services for their resident population on a 24-hour basis. The Facility assessment dated [DATE] documented the following requirements for staffing: One Registered Nurse, one Licensed Practical Nurse, and four Certified Nursing Assistants on all four units (2 South, 2 North, 3 South, 3 North) from 7 am-PM, one Registered Nurse, one Licensed Practical Nurse, and four Certified Nursing Assistants on all four units from PM-1, and one Registered Nurse, one Licensed Practical Nurse, and three Certified Nursing Assistants on all four units from 1-7 am. Upon review of the staffing schedule dated 12/23/24 and 1/18/25, on the 11-PM shift, there were only 2 certified nurse aides working on unit 2 south. Upon review of the staffing schedule dated 12/29/24 and 1/5/25 on the 11-PM shift, there were only 2 certified nurse aides working on unit 3 North. During an interview on 01/22/25 at 10:39 AM, Certified Nurse Aide #1 stated they worked short of staff mostly on the weekends. Certified Nurse Aide #1 stated when they worked with 4 certified nurse aides, they each got approximately 15 residents, and sometimes it was hard to get to the residents on time and the residents had to wait a while, making it difficult to do a good job when working short. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a Resident Council meeting on 1/23/25 at 10:43 AM, eleven residents were in attendance, including the President and [NAME] President, and multiple residents verbalized concerns about staffing. The Resident Council President stated staffing numbers were low and staff worked with below minimum number of Certified Nurse Aides. They believe this to be due to call outs from overworked and floating Certified Nurse Aides. Residents stated they need more Certified Nurse Aides to distribute meal trays for hot meals and assist with feeding. During an interview on 01/29/25 at 8:29 AM, the Staffing Coordinator stated they were unaware the facility assessment indicated the minimum amount of certified nurse aides that could work on the night shift was 3. The Staffing Coordinator stated that although it was difficult and the units were heavy, the units could operate with only 2 certified nurse aides. The Staffing Coordinator reviewed the schedules for 12/23/24, 12/29/24, 1/5/25, and 1/18/25, and confirmed that as per the facility assessment, the units were inadequately staff and did not meet the minimum requirements for staffing. During an interview on 01/29/25 at 9:13 AM, the Administrator stated that that the facility assessment was updated on 8/8/24 and the staffing was entered in error. The Administrator stated that they update the facility assessment annually and review it quarterly at the Quality Assurance and Performance Improvement (QAPI) meetings. During an interview on 01/29/25 at 9:17 AM, the Director of Nursing Stated the facility assessment should be reflecting the minimum staffing for each unit on the night shift, should be 2 certified nurse aides. They stated 2 certified nurse aides on the night shift was enough to care for the residents. The Director of Nursing stated that they tried to put an extra certified nurse aide on 2 North because of the acuity of the unit. 2. During an interview on 01/23/25 at 11:09 AM, Resident #1 stated that there have been times when there is not enough staff, and they must wait for care or can't get out of bed because of it. Night and weekend staffing was described as the worst. They were able to provide three dates when the Certified Nursing Assistant staffing was very short: 8/27/2023, 1/7/2024, and 7/6/24. In addition, they stated there were only 2 Certified Nursing Assistants on an overnight shift last week. The staffing sheets documented that there were only two Certified Nursing Assistants on the 11 PM-7 AM shift on 1/6/24, 1/7/24, 7/5/24, and 1/18/25. There were only three Certified Nursing Assistants on the 7 AM-3 PM shift on 8/26/23 and 8/27/23. During an interview on 01/29/25 at 04:21 PM, the Staffing Coordinator stated that the staffing PAR levels are determined by the maximum number of residents on each unit. Stated that the minimum number of Certified Nursing Assistants on the 11pm-7 am shift is 2, but they aim for 3. Stated they were not aware that this conflicted with the facility assessment. Stated that weekends are more often short compared to weekdays. Stated they do have two Certified Nursing Assistants at times on some of the units for the overnight shift. 10NYCRR 415.13(a)(1)(i-iii)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335459	A. Building B. Wing	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westchester Center for Rehabilitation & Nursing	10 Claremont Ave Mount Vernon, NY 10550

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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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation and interview conducted during the recertification survey 1/22/25-1/29/25 the facility did not ensure that garbage was contained and disposed of in an appropriate manner. Specifically, the trash compactor had food spilling out of it and the recycled boxes were not maintained within the dumpster. Findings include: An inspection of the dumpster and trash compactor area was conducted on 01/29/25 at 3:24 PM and revealed the dumpster to have the lid open with card bard boxes littered out of the dumpster and onto the ground around the dumpster including up to five feet away from the dumpster. The compactor was observed to have an approximate area of three (3) feet by four (4) feet of food and debris spilling out. A clear plastic bag hanging over the side of the opening of the compactor and what appeared to be various vegetables, rice, paper and plastic food and beverage containers were littered on the ground. When interviewed on 1/29/25 at 3:30 PM, the Food Service Director stated it should not look that way. The boxes should have been broken down and put inside of recycle dumpster. They stated food service workers were trained on how to work the compactor and if garbage falls out, it should be cleaned up immediately. 10 NYCRR 415.14 (h)