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	12/04/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review, observations and interviews during the Abbreviated Survey (2633933) on 10/21/2025-10/22/2025, the facility did not ensure that the resident's representative was notified timely of an incident for (1) one (Resident #1) of (3) three residents reviewed for Abuse. Specifically, on 09/27/2025 Resident #1 had an episode of aggressive altercation with staff resulting in the need for Resident #1 to be sent out for psychiatric evaluation. The resident's representative was not informed of the incident until they visited and were informed by the resident who was visibly upset about the incident. The finding is:The facility's policy titled, Notification of Changes, last revised on 08/2024, documented it is the policy to notify the resident/designated representative when there is an accident/incident involving the resident. Resident #1 was admitted with diagnoses including dementia, legally blind and cellulitis. The admission Minimum Data Set (an assessment tool) dated 09/07/2025 documented the resident had severely impaired cognition. The resident was independent with eating and required partial assistance with activities of daily living. The resident had documented behaviors on 1-3 days in the assessment lookback period. The Accident and Incident report dated 09/27/2025 documented the family was notified, but did not include a date or time. A review of the electronic medical record revealed that the complainant was listed as the primary contact. A review of a Grievance Form dated 09/29/2025 documented the resident's family expressed concern they were not notified that the resident had an event during the time of 9/27/2025. They were only made aware of this incident by the resident when they came to visit in the morning 09/27/2025. The investigation noted the supervisor was counseled for not contacting the family in a timely manner regarding the incident and was reeducated regarding family notification. During an interview on 10/21/2025 at 12:21 PM, the family member stated when they arrived at Resident #1 in the room on 9/27/2025 the resident was visibly upset. They asked their family member why they were upset, and they stated they asked Certified Nurse #1 to keep the door open, and Certified Nurse Aide #1 said no. The family member stated they were informed by Registered Nurse Supervisor #7 that Resident #1 swung a chair and hit the wall early that morning. The family member stated they also expressed to the interdisciplinary during a meeting on 09/29/2025 that they were not notified about the incident on 09/27/2025. The administrator advised them they would investigate why they were not called. During an interview with on 10/22/2025 at 11:40 AM, the Registered Nurse Supervisor #2 stated around 6:00 AM the Registered Nurse #3(Medication Nurse) asked them to come to unit 2. Upon arrival they saw. Certified Nurse Aide #1 sitting outside Resident #1's room, and the resident was sitting on the bed. Certified Nurse Aide #1 pointed out indentations in the wall. They had asked the resident what happened, and the resident stated they hit the wall, they were sorry and would not do it again. An Incident report was completed at the end of the shift. They stated they believe they had reached out to the family around 8:00 AM, but do not recall if they left a message. They stated they did not call immediately because the resident was assessed and was fine. They were called by the facility later that week and asked why they did not notify the family of the incident. They were counseled and reeducated by the facility about the need for timely family notification. During an interview on 10/21/2025 at 12:15PM, the Assistant Director of Nursing stated they attended the meeting on Monday 09/29/2025 where the family expressed concern over not being notified regarding the event on 09/27/2025. They wanted to know what happened during the event of 09/27/2025 before consenting to send the resident out for a psychiatric evaluation. The family requested an investigation as to why they were not notified. An Investigation was completed the supervisor was educated on ensuring timely family notification when an incident occurs. During an interview on 10/21/2025 at 1:27 PM, Social Worker # 6 stated they were made aware on Monday, 09/29/2025 that the resident's family wanted to have a meeting about the incident that occurred on Saturday, 09/27/2025. During the meeting, the family questioned why they were not notified of the incident. The Administrator advised them the facility would investigate the occurrence. A grievance was initiated as to why the family was not called about the incident. During an interview on 10/22/2025 at 9:30 AM, the Administrator stated that they attended the interdisciplinary meeting on 09/29/2025 regarding Resident #1 and the behaviors that staff felt required the resident to be further evaluated. The family was present at the meeting. The family expressed concern regarding the lack of communication and that they were not notified of the incident that occurred on 09/27/2025. The family informed them they found out about the incident from the resident when they came to visit in the morning. The administrator stated they initiated a grievance, and the investigation/grievance found the family was not notified timely of the incident. The nursing supervisor was counseled and reeducated