

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335495	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/21/2026
NAME OF PROVIDER OR SUPPLIER Wayne Center for Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3530 Wayne Avenue Bronx, NY 10467	
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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure that the resident and their representative were provided with a copy of the resident health care records upon written request and two working days' advance notice to the facility. This was evident for one of two residents (Resident #15) reviewed for Choices and one of two residents (Resident #117) reviewed for Notification of Change out of 38 sampled residents. Specifically, 1) Resident #15 requested medical records on 05/25/2026, which were not received until 06/09/2026, and 2) Resident #117's representative requested medical records on 05/29/2026, which were not received until 06/15/2026. The findings include: The facility policy and procedure titled Medical Records last revised in January 2025, documented that it is the facility's policy to release clinical information to those requesting it in a timely manner, within two business days. 1. Resident #15 was admitted to the facility with diagnoses that include diabetes mellitus, (a chronic condition where high blood sugar occurs because the body cannot make enough insulin or use it proper) and coronary artery disease (a condition where the major blood vessels supplying the heart get narrow or blocked). The Quarterly Minimum Data Set assessment dated [DATE] documented Resident #15 is cognitively intact and participated in assessment and goal setting. During an interview on 07/14/2026 at 11:54 AM, Resident #15 stated that it has been two months since they requested their medical records and that the social worker had not gotten back to them. Resident #15 presented a copy of the completed form to the state surveyor, indicating a request for medical records and stated that they requested the medical records themselves. A care plan note dated 05/06/2026 by Social Worker #2, documented that Resident #15 requested medical records copy, however documents were given to Resident #15 to sign for the HIPPA (Health Insurance Portability and Accountability Act) consent and social worker has been constantly asking for it, to proceed with their request. There was no documented evidence Resident #15 was provided with a copy of their medical record (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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	within two working days of their request. On 07/20/2026 at 10:09 AM, Social Worker #2 was interviewed and stated that they are the assigned social worker for Resident #15. Social Worker #2 also stated that when Resident #15 was transferred to the 4th floor, they had been requesting documents, so the social worker gave Resident #15 the form to complete and stated that Resident #15 never returned the form that they gave them to complete. On 07/20/2026 at 12:41 PM, Social Worker #3 was interviewed and stated that Resident #15 had requested their medical records and that they received it via a disc, but Resident #15 requested paper copies. Social Worker #3 also stated that they informed Resident #15 that there would be a charge if they got a large amount of paper, and that if they wanted something specific, then they would request the specific pages from the Administrator. Social Worker #3 further stated that they were just assisting Resident #15 and was not aware of how long it took for Resident #15 to receive the documents. On 07/20/2026 at 3:29 PM, the Medical Records Director was interviewed and stated that Resident #15 requested the medical records on 05/25/2026 and they were given to them on 06/09/2026. The Medical Records Director also stated that Resident #15 made the request themselves on 05/25/2026, and when a request is made, the process should take about 48 hours to get the requested information. On 07/21/2026 at 2:12 PM, the Administrator was interviewed and stated that they spoke with Resident #15 about the medical records which were 8000 pages and would fill about two boxes. The Administrator also stated that Resident #15 did not ask for anything else and that the time frame for receiving the medical records depends on corporate compliance as if there is any discrepancy that would be reviewed first. 2. Resident #117 was admitted to the facility with diagnoses that included Chronic Obstructive Pulmonary Disease (a progressive lung disease that makes it difficult to breathe) and dementia (a pattern of mental decline). The Minimum Data Set (an assessment tool) dated 05/19/2026 documented Resident #117 had moderately impaired cognition, and their representative participated in the assessment. During an interview on 07/14/2026 at 11:36 AM, Resident #117's representative stated that Resident #117 fell on [DATE], and they requested a copy of their medical records on 05/29/2026 and received them about a month ago. A review of the Authorization for Release of Health Information form revealed that Resident #117's representative submitted the request to the facility on [DATE]. During an interview on 07/20/2026 at 3:08 PM, the Medical Records Director stated that if a resident or family requests medical records, they must submit a request form, which is sent to their corporate compliance department. The Medical Records Director also stated that once corporate compliance approves the request, they compile the information, they present it to the administrator and provide it (continued on next page)		

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F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to the family representative after the administrator approves it. The Medical Records Director further stated it takes 72 hours for someone to receive their medical records after they request them. The Medical Records Director stated they needed the health care proxy authorization from Resident #117's representative before they could release the records. During an interview on 07/20/2026 at 3:15 PM, the Administrator stated that the medical record request takes 24&ndash;48 hours, and it also depends on when they receive the request. The Administrator also stated they received the request from Resident #117's representative on 05/29/2026. Their corporate compliance office requested a copy of the health care proxy authorization before they could approve the request, and Resident #117's representative was made aware. The Administrator further stated that on 06/11/2026, the Medical Records Director reached out to Resident #117's representative, and they stated that they did not have the health care proxy authorization, so they decided that since the representative is active in Resident #117's care, they approved the request, and the records were picked up on 06/15/2026. 10 New York Codes, Rules and Regulations 415.3(d)(1)(iv)		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Number of residents sampled: 2Number of residents cited:1Based on record reviews and interviews, the facility failed to make prompt efforts to resolve grievances. This was evident for one resident (Resident #131) of two residents reviewed for Personal Property. Specifically, facility failed to investigate and provide a written grievance decision to Resident #131's representative regarding missing personal items. The findings include:The facility policy titled Grievance Reporting and Response, dated 01/01/2017 and last revised 10/30/2019, documented that the facility is responsible for investigating and responding to all resident grievances in a timely manner. The policy identified the Social Services Department as responsible for overseeing the grievance process, including receiving, tracking, investigating, and following grievances through to resolution. The policy further required that an investigation be initiated within 48 hours of receipt of the grievance and that both the resident and the complainant be notified in writing of the investigation's outcome. In addition, the facility was required to document the receipt, review, investigation, and disposition of each grievance, including the name of the complainant and resident, a summary of the grievance, and the staff member designated to conduct the review and investigation.Resident #131 had diagnoses that included congestive heart failure (a chronic condition where the heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen), coronary artery disease (a condition when the blood vessels that supply your heart get clogged, making it harder for your heart to get the blood and oxygen it needs). cerebrovascular accident (also called a stroke or brain attack-happens when blood flow to part of the brain is suddenly blocked or stopped)The Quarterly Minimum Data Set (a resident assessment tool) dated 01/30/2026, documented Resident #131's memory was severely impaired, they required supervision during transfers between the chair and bed, and their family representative participated in the assessment and goal setting process.On 07/15/2026 at 10:14 AM, Resident #131 was observed alert and awake and seated in a wheelchair in the hallway. Resident #131 appeared confused and was able to respond to name and engage in minimal conversation.During an interview conducted on 07/21/2026 at 12:45 PM, Resident #131's representative stated that several personal belongings had gone missing from the resident's closet. Resident #131's representative also stated that all items were labeled when brought to the facility and that the nursing staff maintained a record of the items provided for the resident. Resident #131's representative further stated shoes, clothing, and even food stored in the dining room refrigerator had disappeared, and they had met with the social worker on several occasions regarding the missing items but felt that their concerns were not believed. A review of an email sent to the facility social worker dated 04/21/2026 documented a concern reported by Resident #131's family representative who stated that they had purchased three pairs of shoes for Resident #131, however, all three pairs were reportedly missing. The family representative requested assistance from the facility in replacing the missing items.A review of the family representative's undated, handwritten and signed note which was attached to the email dated 04/21/2026, documented that this was the third time Resident #131 had been missing shoes and a request was made for the facility to get shoes for the resident as they were not going to be purchasing items again.There was no documented evidence that a Resident #131's representative had voiced a grievance or that the grievance had been followed up on and resolved by the facility. During an interview on 07/20/2026 at 10:34 AM, Registered Nurse #8 stated that the resident's family representative approached them on 04/21/2026 in the evening hours and reported concerns regarding missing shoes belonging to the resident. Registered Nurse #8 also stated (continued on next page)		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that the social worker was not available at that time. Registered Nurse #8 further stated that the family representative reported they had previously informed Social Worker #1 about the missing items; however, no action had been taken. Registered Nurse #8 stated that they sent an email to Social Worker #1 regarding the concern and attached a handwritten note from the family representative. Registered Nurse #8 further stated that they informed Social Worker #1 about the missing shoes, either that same day or the next day. During an interview on 07/20/2026 at 10:51 AM, Social Worker #1 stated that when family members bring personal items for residents, the items should be documented and labeled to assist with tracking and accountability if items become missing. Social Worker #1 also stated that the family representative had previously reported missing sneakers and that they had begun addressing the concern. Social Worker #1 further stated that the family representative later informed them that they had purchased another pair of shoes for the resident. Social Worker #1 stated that there was no documentation in the resident's medical record regarding the outcome or resolution of the missing items concern. 10 New York Code Rules and Regulation 415.3(d)(1)(i)		

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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** Number of residents sampled: 4Number of residents cited: 1 Based on observation, record review, and interview, the facility failed to ensure that the resident received adequate supervision to prevent accidents. This was evident for one resident (Resident #131) of four residents reviewed for accidents. Specifically, Certified Nursing Assistant #10 did not provide the necessary supervision to a severely confused resident who was also identified as restless, agitated, and at high risk for falls during an attempted transfer to bed. Certified Nursing Assistant #10 left Resident #131 alone in the room, and Resident #131 attempted to transfer independently and fell while trying to get into bed without assistance. Upon re-entering the room, Certified Nursing Assistant #10 placed Resident #131 back into bed without first notifying the nurse or obtaining an assessment by the nurse. Resident #131 sustained a left subtrochanteric hip fracture (a break in the upper portion of the left thigh bone).The findings include:The facility's policy and procedure titled Accident Prevention Reporting and Investigation dated 06/06/2021, documented that, the facility will provide an environment that is free from accident hazards for the safety of residents, and identify the cause of accidents and obtain appropriate care for the injured residents. The facility policy also documented that the facility would implement individualized fall prevention interventions by closely monitoring residents for cognitive impairment, communication deficits, and visual limitations that may affect safety awareness. Staff will observe behaviors that increase fall risk, including wandering, restlessness, impulsiveness, and poor safety judgment, and provide supervision and redirection as needed.Resident #131 had diagnoses that included congestive heart failure (a chronic condition where the heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen), coronary artery disease (a condition when the blood vessels that supply your heart get clogged, making it harder for your heart to get the blood and oxygen it needs) and cerebrovascular accident (also called a stroke or brain attack-happens when blood flow to part of the brain is suddenly blocked or stopped).Review of the Minimum Data Set assessment (a resident assessment tool) dated 01/30/2026 revealed that Resident #131's memory was severely impaired, and they required supervision when transferring from a chair to the bed. On 07/15/2026 at 10:14 AM, Resident #131 was observed alert and awake and seated in a wheelchair in the hallway. Resident #131 appeared confused and was able to respond to name and engage in minimal conversation.Review of a registered nurse note dated 02/14/2026 11:0PM, documented that at 05:35 PM, Certified Nurse Assistant #2 reported that Resident #131 complained of pain to the left thigh following transfer from wheelchair to bed. The note also documented that Resident #131 was assessed immediately and noticed with swelling to the left thigh. Area was tender to palpation with increased pain upon movement. Resident rated pain at 7/10 on numeric pain scale. Resident denied any fall, and no fall was witnessed or reported by staff. Nursing supervisor was notified of change in condition, medical provider informed and order received for stat X-ray of left thigh and hip. Tylenol 625 mg administered as per order for pain management. Resident repositioned for comfort and movement minimized pending diagnostic evaluation.Review of a registered nurse note dated 02/15/2026 2:49PM, documented Resident #131 was observed in bed, noted with swelling to left knee, thigh and hip. Complained of pain to left lower extremity, rated pain as 6/10, pain management, Tylenol 650mg given every 8 hours as ordered with some effect. X-Ray results of left hip demonstrate a subtrochanteric fracture. Resident was sent to the hospital around 3:35PM on 02/15/2026.The review of x-ray reports dated 02/15/2026 revealed two views of the pelvis and left hip demonstrate a (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	subtrochanteric fracture of the left hip. The facility investigation dated 02/14/2026 documented that, on 02/14/2026 at 05:35 PM, Certified Nurse Assistant #10 stated that they wheeled Resident #131 to the room and then stepped out to get additional supplies needed for care. Upon entering the room, they observed the resident transferring self into bed. Certified Nurse Assistant #10 observed that resident legs were bent, so the Certified Nurse Assistant #10 moved quickly to assist Resident #131 to prevent them from falling. Certified Nurse Assistant #10 also stated they lifted Resident #131 and swung them to the bed, and a few minutes later, resident started complaining of pain to left hip. X-Ray was ordered and result demonstrated a subtrochanteric fracture of the left hip. The facility investigation concluded that, based on investigation conducted through staff interviews, statements, the clinical documentation, there was no evidence of abuse, neglect or mistreatment that occurred relevant to the left acute subtrochanteric fracture. The investigation further stated the left hip must have been accidentally twisted when the Certified Nursing assistant #10 lifted and swung resident towards the bed causing the angulated fracture of the left femoral shaft. Review of hospital discharge records dated 03/02/2026 revealed that Resident #131 presented to the hospital on [DATE] with left subtrochanteric hip fracture and underwent left femur intramedullary nail (a surgical procedure where a metal rod is inserted into the femur to stabilize a fracture and allow early mobilization) surgery on 02/17/2026 and can bear weight on the left lower extremity as tolerated. The nursing readmission note dated 03/02/2026 documented that Resident #131 returned from hospital, was recently sent out due to left hip fracture. Resident was observed with post operative surgical sites, including eleven staples to left upper hip, twenty-two staples to left mid hip and seven staples to the left lower hip. The Care Plan Activity Report for focus Behavioral Symptoms effective 07/18/2024, and last revised on 11/10/2025 documented that Resident #131 manifested behavioral problems by constantly trying to get out of bed by rolling self-off bed and sliding off self from wheelchair. The care plan also documented that the resident is restless, tried to get out of bed, and fall precautions maintained. Bed on the lowest position, with floor mat on the right side of the bed, fall safety maintained. During a telephone interview conducted on 07/17/2026 at 9:37 AM, Certified Nursing Assistant #10 stated that they wheeled Resident #131 to their room and then stepped out briefly to obtain needed supplies because there were not enough supplies available in the room. Certified Nursing Assistant #10 also stated that the wheelchair had been locked before leaving the resident. Upon returning, Certified Nursing Assistant #10 stated that, as they approached the room, they heard Resident #131 screaming and observed resident attempting to self-transfer from the wheelchair to the bed and was halfway to the floor. Certified Nursing Assistant #10 stated they quickly grabbed Resident #131 and placed them onto the bed. Certified Nursing Assistant #10 stated Resident #131's leg appeared to twist during the transfer and they immediately began complaining of pain. During a further interview conducted 07/17/2026 at 10:30 AM, Certified Nursing Assistant #10 stated that Resident #131 had a history of behaviors in which they would sometimes propel themselves in and out of the wheelchair or attempt to move independently. Certified Nursing Assistant #10 also stated that since this was Resident #131's typical behavior the resident should have been more closely monitored. The Certified Nursing Assistant #10 stated they were gone for a short time and did not expect this to happen in such a short period of time. During an interview conducted on 07/17/2026 at 10:29 AM, the Director of Nursing stated that staff should not attempt to lift a resident after a fall and instead should immediately notify the registered nurse as the resident should not be lifted unless a Registered Nurse is present. The Director of Nursing also stated that the facility investigated the incident and determined that Resident #131 was in the process of falling. The Director of Nursing further stated Resident #131 required a one-person assist because they were able to pivot during transfers. The Director of Nursing stated (continued on next page)		

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. Number of residents sampled: 4Number of residents cited: 1 Based on observation, record review, and interviews, the facility failed to ensure medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident were provided. This was evident in one resident (Resident #131) of four residents reviewed for Discharge out of 38 sampled residents. Specifically, there was no documented evidence in the resident's medical record that appropriate information was communicated to the receiving facility when Resident #131's representative request a transfer to another facility. The findings include:The facility policy and procedure titled Discharge/Transfer, dated 01/25/2025, documented that the facility social worker is responsible for coordinating the discharge and transfer process and ensuring an effective transition. The social worker is to meet with the resident and/or the resident's representative to determine the reason for the requested transfer and identify any concerns related to care, safety, resident preferences, dissatisfaction with services, family concerns, financial issues, or changes in the resident's medical needs. The policy also documented that when a discharge or transfer is necessary, the social worker is responsible for providing information regarding available facilities that may meet the resident's needs, assisting the resident or family with contacting potential receiving facilities, as appropriate, and documenting all discharge or transfer activities in the resident's medical record.Resident #131 had diagnoses that included congestive heart failure (a chronic condition where the heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen), coronary artery disease (a condition when the blood vessels that supply your heart get clogged, making it harder for your heart to get the blood and oxygen it needs). cerebrovascular accident (also called a stroke or brain attack-happens when blood flow to part of the brain is suddenly blocked or stopped)The Quarterly Minimum Data Set assessment (a resident assessment tool) dated 01/30/2026 documented Resident #131's memory was severely impaired, hey required supervision when transferring from chair to bed. The assessment also documented that the resident's family representative participated in the assessment and goal setting.On 07/15/2026 at 10:14 AM, Resident #131 was observed alert and awake and seated in a wheelchair in the hallway. Resident #131 appeared confused and was able to respond to name and engage in minimal conversation.Review of the social services note dated 03/10/2026 revealed that Resident #131's representative expressed a desire for the resident to be transferred to another facility. The social worker explained the process for transferring a resident from one nursing home to another. Resident #131's representative verbalized understanding and stated that they would provide the social worker with the names of several facilities they wished to explore for possible placement.The social services note dated 03/24/2026 documented that, as per family member's request, the Patient Review Instrument and additional required documentation were faxed to a nursing facility for review and consideration of possible admission.The nursing progress note dated 05/21/2026 documented that Resident #131 was evaluated by orthopedics on 05/18/2026 for a follow-up appointment related to a left hip fracture. The orthopedic consultation documentation included a note indicating that the resident's family member reported that Resident #131 does not feel safe in the facility and requested that the resident be transferred to another facility. The note instructed that Social Services be contacted for follow-up.Review of the medical record revealed no further documentation regarding follow-up on transfer to any other facilities, the status of the transfer request, or how updates related to the transfer process were communicated to the resident's family member.During an interview on (continued on next page)		

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	07/21/2026 at 10:31 AM, Registered Nurse #9 stated that the resident's family representative had expressed concerns on multiple occasions and was upset, requesting that the resident be transferred to another facility. Registered Nurse #9 also stated that they asked the family representative if there were concerns regarding the care being provided or if the facility was not meeting the resident's needs; however, the resident's sister continued to insist that the resident be transferred. Registered Nurse #9 further stated that the family's concerns were communicated to the facility social worker for follow-up. During an interview on 07/21/2026 at 11:00 AM, Social Worker #1 stated that part of their roles is to assist with facilitating, coordinating, and supporting a safe and appropriate transfer transition when a resident or representative requests a transfer. Social Worker #1 also stated that Resident #131 had severe confusion and that the resident's family members were responsible for participating in the resident's care planning process. Social Worker #1 further stated that they met with the resident representative to discuss the reason for requesting a transfer and they advised the family representative to identify a facility of choice before the transfer process could proceed. Social Worker #1 stated that the family representative later provided a facility name, and they contacted the facility and faxed the Patient Review Instrument and other required documentation. Social Worker #1 stated that they did not receive a response from the receiving facility and that there was no additional documentation regarding further follow-up after the records were sent. During an interview conducted on 07/21/2026 at 12:44 PM, the Administrator stated that Resident #131 was receiving good care at the facility and that they were not aware of another facility willing to accept the resident at that time. The Administrator also stated that the resident's records had been sent to multiple nursing facilities, but no facility had accepted the resident. 10 New York Code Rules and Regulation 415.5 (g)(1)(i-xv)		