

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335690	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2025
NAME OF PROVIDER OR SUPPLIER White Oaks Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8565 Jericho Turnpike Woodbury, NY 11797	

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)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

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: 335690	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2025
NAME OF PROVIDER OR SUPPLIER White Oaks Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8565 Jericho Turnpike Woodbury, NY 11797	
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)		
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review during an abbreviated survey conducted on 10/28/2025 for case number 2616775, the facility failed to ensure one (1) (Resident #1) of three (3) residents was free from accidents. Specifically, Certified Nursing Assistant #1 failed to follow the care plan for Resident #1 requiring a two-person assist. On 09/11/2025, Certified Nursing Assistant #1 transferred Resident #1 from their wheelchair to their bed alone resulting in a fractured left humerus (upper arm bone). This resulted in actual harm to Resident #1 that is not Immediate Jeopardy. Resident #1 was admitted on [DATE] with diagnosis that include vascular dementia (a decline in thinking skills caused by conditions that damage blood vessels and reduce or block blood flow to the brain,) cerebral vascular accident (stroke,) and osteoarthritis. On 08/21/2025, a Minimum Data Set (a resident assessment tool) Brief Interview of Mental Status was completed for Resident #1 and documented a score of 99 indicating severe cognitive impairment. Facility Safe Patient Transfer Policy dated 11/02/2024 and revised 09/12/2025, documented before any transfer, staff must: Review patient's mobility level, weight-bearing status, cognitive ability, and cooperation, review care plan and physician orders for mobility or transfer restrictions. Identify risk factors (e.g., weakness, pain, wounds, lines/tubes), determine appropriate number of staff and equipment needed. Medical Doctor Orders for Resident #1 dated 08/29/2025 at 3:04 PM documented transfer: out of bed to reclining back wheelchair with assist x 2 daily, (Two-Person Lift). Nursing Progress Notes dated 09/12/2025 at 6:56 AM documented Certified Nursing Assistant #2 reported a bruise was observed while providing care. Upper arm was noted with a bruise, swollen and painful when Resident #1 tries to move the arm. The Medical Doctor was made aware of bruise to left upper arm and ordered an X-ray to left arm. Nursing Progress Notes dated 09/12/2025 at 7:37 AM documented Resident #1's Family Member #1 was notified of left arm ecchymosis (bruising) and plan for x-ray. Orders placed for physical therapy/occupational therapy evaluation as left arm is painful. Nursing Progress Note dated 09/12/2025 at 11:50 PM documented Resident #1 alert, X-ray results reviewed with Medical Doctor. Acute fracture proximal humerus is noted, Tylenol given, place left arm on a pillow, place in sling and needs orthopedic follow up as per Medical Doctor order. Facility Accident/Incident Report finalized on 09/15/2025 documented, on further investigation via telephone conference call with Director of Nursing and Licensed Practical Nurse Risk Manager while interviewing evening Certified Nursing Assistant #1, it was stated by them that they had placed Resident #1 to bed around 7:00 PM on 09/11/2025 and transferred them out of their wheelchair to the bed by themselves and explained how they wrapped their arms around Resident #1's body while the resident's arms were at rest at the side of their body and lifted them out of the wheelchair to bed. When Licensed Practical Nurse Risk Manager asked them to further explain and elaborate on that transfer technique, Certified Nursing Assistant #1 replied with stating again that they wrapped their arms around Resident #1 and lifted them up like a bear hug and placed them into the bed. Certified Nursing Assistant #1 stated that they then provided PM care and left the resident in bed without seeing any bruising or injury or any signs or symptoms of discomfort during care. As Licensed Practical Nurse Risk Manager and Director of Nursing reviewed Resident #1's transfer plan of care it was discovered that this was a violation to the care plan, as Resident #1 had orders for a two (2) person assist with transfers. The Director of Nursing instructed Certified Nursing Assistant #1 be removed from the facility and sent home pending further investigation. Facility Accident/ Incident Report further documented Certified Nursing Assistant #1's transfer against Medical Doctor's order contributed to Resident #1's humerus fracture and harm. The incident report further documented medical orders were received for sling application, pain management with Tylenol, and therapy evaluation, and anticoagulation therapy was held due to the fracture. The resident's family was notified, and pain management was subsequently adjusted with additional medication. An orthopedic follow-up was arranged, and the resident has remained stable with immobilization in place and ongoing therapy support. During a telephone interview conducted by the State Agency with Certified Nursing Assistant #1 on 11/04/2025 at 9:39 AM, they stated they transferred Resident #1 from the chair to the bed alone. The nurse told Certified Nursing Assistant #1 to put Resident #1 in bed. Certified Nursing Assistant #1 stated they transferred Resident #1 by seat of pants to bed. Resident #1 had always been a one-person assist. Suddenly, they changed Resident #1 to a two-person assist. They work part time. They didn't have Resident #1 all the time because they float units. They don't know what happened to cause injury to Resident #1. Resident #1 had fallen one or two weeks ago. Certified Nursing Assistant #1 further</p>		