

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

Printed: 06/27/2024
Form Approved OMB
No. 0938-0391

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 03/09/2024
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)		
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44963 Based on observations, record review and interviews conducted during a Recertification Survey initiated on 3/4/2024 and completed on 3/9/2024, the facility did not ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown sources, were reported to the New York State Department of Health. This was identified for one (Resident #119) of eight residents reviewed for Accidents. Specifically, Resident #119, with a diagnosis of Dementia and impaired cognition, sustained the following unwitnessed injuries of unknown origin 1a) a laceration to the right arm which required transfer to the hospital and treatment of 16 staples on 12/6/2023, 1b) ecchymotic (bruise) area to the left buttock on 2/27/2024 and 1c) ecchymotic area to left upper inner forearm and right outer arm on 2/29/2024. The facility did not report Resident #119's injuries of unknown origin to the New York State Department of Health. The findings are: The facility's policy titled, Abuse Prevention and Reporting last revised in January 2020 defined Injuries of Unknown Origin as when the source of the injury was not observed by any person or the resident could not explain the source of the injury and the injury is suspicious because of the extent of the injury or the location of the injury. Under the section Reporting, all alleged cases of abuse, neglect, or mistreatment will be reported to the Department of Health or any other agency as appropriate by the Administrator and the Director of Nursing Services. All alleged violations must be called in immediately, but no later than two hours if the alleged violation involves abuse or results in serious bodily injury, or 24 hours if the alleged violation does not involve abuse and does not result in serious bodily injury. Resident #119 was admitted with diagnoses including Dementia, Anxiety, and Lack of Coordination. The Quarterly Minimum Data Set assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 99 which indicated the resident was unable to complete the interview. The Minimum Data Set documented that Resident #119 was sometimes able to understand and be understood and did not exhibit behaviors of rejection of care or wandering. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Comprehensive Care Plan for Aggressor/Victim dated 6/9/2021 and last reviewed on 2/4/2024 documented the resident has a potential of being an aggressor or victim as evidenced by being easily agitated, continuing to ambulate ad lib (as much and as often as desired) on the unit, and wandering in peers' rooms at times. Interventions included but were not limited to monitoring behaviors, and redirecting away from situations that cause frustrations when resident raise fists. On 7/10/2023 interventions were updated to include 30-minute visual checks, and on 10/3/2023 the interventions were updated to include one to one supervision. A Comprehensive Care Plan for Falls dated 6/9/2021 and last reviewed on 2/27/2024 documented the resident was at risk for falls/injuries secondary to a history of falls, psychotropic drug use, impaired vision, and Dementia. Interventions included to investigate the cause of the fall immediately and to ensure the use of proper footwear. The care plan interventions were updated on 12/18/2023 to include one to one monitoring at all times. 1a) An Accident and Incident Report dated 12/6/2023 at 9:30 PM documented Resident #119 was noted with a laceration to the right arm. The resident was unable to explain what happened. The location of the incident was unknown. A Certified Nursing Aide observed the resident with their (Resident #119) right arm bleeding. The Accident and Incident report was not signed by the nurse who initiated the report and also did not identify the Certified Nurse Aide who had initially reported the resident's injury. A statement written by Certified Nursing Aide #2 dated 12/6/2023 documented that Certified Nursing Aide #2 was assigned to Resident #119 and saw Resident #119 at approximately 5:30 PM in the hallway. Certified Nursing Aide #2 documented that the resident was seen eating dinner in the dining room around 5:50 PM. Certified Nursing Aide #2 documented they did not witness the incident or any environmental issue that may have contributed to the incident. The written statement did not indicate that Certified Nursing Aide #2 had observed Resident #119's right arm injury on 12/6/2023. A nursing progress note dated 12/7/2023 by Licensed Practical Nurse #3 documented that Licensed Practical Nurse #3 was called to the resident's room around 9:30 PM on 12/6/2023. Upon arrival, the resident was observed with a laceration of unknown origin to the right forearm. The resident was transferred to the hospital for possible sutures. The resident's physician was notified. A nursing progress note dated 12/7/2023 documented that the resident returned from the hospital with 16 staples on the right forearm intact with a small amount of blood noted. Staples removal on 12/14/2023. Doxycycline antibiotic therapy for wound infection as ordered. The summary of the investigation dated 12/7/2023 documented that at 9:30 PM on Thursday 12/6/2023 (12/6/2023 was a Wednesday) Certified Nursing Aide #2 found Resident #119 in another resident's room with a large laceration on their (Resident #119) right forearm. Certified Nursing Aide #2 called for a nurse. Licensed Practical Nurse #3 came and applied pressure on the wound. A Physician was notified and the resident was transferred to the hospital. The investigation summary documented that when Resident #119 was found with the right-arm laceration, they (Resident #119) were standing with a piece of wood from the dresser in their hand and it was determined the resident scraped their arm with the piece of wood that resulted in a laceration. The investigation concluded that there was no cause to believe abuse, mistreatment, or neglect had occurred. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility investigation did not include statements from the resident or the staff member who initially found the resident with the laceration. Furthermore, there were no statements from the staff members who allegedly saw the resident holding a piece of wood that may have caused the laceration to the resident's right arm. Certified Nursing Aide #2 was interviewed on 3/8/2024 at 4:14 PM and stated that they were assigned to Resident #119 on 12/6/2023 during the evening shift. Certified Nursing Aide #2 stated they helped the resident during dinner time and last saw the resident around 6:00 PM. Certified Nursing Aide #2 stated they had dressed the resident before dinner and the resident did not have any injuries to their right arm. Certified Nursing Aide #2 stated they did not witness the resident sustaining the injury and were not the one who found the resident with the laceration. Certified Nursing Aide #2 stated they did not know how the resident got hurt. 1b) An Accident and Incident Report dated 2/27/2024 documented Resident #119 was observed with an ecchymotic area to their left buttock. The resident was unable to state what happened secondary to impaired mental status. The location of the incident was unknown. The Registered Nurse assessment documented the resident was alert and responsive with confusion with no signs and symptoms of pain or discomfort. A statement written by Certified Nursing Aide #4 dated 2/27/2024 documented that Certified Nursing Aide #4 was assigned to Resident #119 and observed a purple bruise around Resident #119's left buttock during care. Certified Nursing Aide #4 documented they immediately notified the nurse. Certified Nursing Aide #4 documented that the incident was not witnessed by any personnel or visitor. The summary of the investigation dated 2/28/2024 documented that on Tuesday 2/27/2024 around 11:00 AM Certified Nursing Aide #4 was changing Resident #119's brief and noticed a bruise on the resident's left buttock. Resident #119 was on 1:1 supervision and had no falls or incidents of late. Upon investigation, the interdisciplinary team determined that the ecchymotic area on the resident's left buttock could be from their buttock hitting against the arm of a stationary chair and/or the bench in the unit dining room as the resident was attempting to sit. The resident is up and down in chairs in their room and the unit dining room all day with a 1:1 staff member by their side. At times the resident needed assistance and redirection with sitting and standing. The investigation concluded that there was no cause to believe abuse, mistreatment, or neglect had occurred. The Accident and Incident report or the Investigation Summary did not include statements from the staff from the previous shift to determine the root cause of the injury of unknown origin. 1c) An Accident and Incident Report dated 2/29/2024 documented on 2/29/2024 at 3:00 PM, Resident #119 was observed with an ecchymotic area to their right outer arm near the armpit and to their left upper inner forearm. The resident was unable to explain the cause of the injuries due to cognitive impairment. The location of the incident was documented as unknown. The Registered Nurse assessment documented a visible ecchymotic area on both left and right arms, there was no swelling observed. The Accident and Incident report was not signed by the staff member who completed the report. A verbal statement obtained by the facility from Certified Nursing Aide #5 dated 2/29/2024 documented that Certified Nursing Aide #5 was assigned to Resident #119 and observed bruises while changing the resident. The resident did not fall while they were with Certified Nursing Aide #5. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The summary of the investigation dated 3/1/2024 documented that on Thursday 2/29/2024 Certified Nursing Aide (not identified in the summary) was providing care and noticed slightly reddened/ecchymotic areas on the resident's left and right upper arms. The resident had no falls or incidents and remained on 1:1 supervision for safety. The summary concluded that if the resident pulled away quickly while a staff member was redirecting or guiding the resident by gently holding the resident, the resident could possibly injure their fragile skin which caused purpura or ecchymosis. The investigation concluded that there was no cause to believe abuse, mistreatment, or neglect had occurred. The Accident and Incident report or the Investigation Summary did not include statements from the staff from the previous shift to determine the root cause of the injuries of unknown origin. Certified Nursing Aide #5 was interviewed on 3/8/2024 at 2:29 PM and stated that they were the assigned 1:1 staff for Resident #119 on 2/29/2024. Certified Nursing Aide #5 stated that they did not receive reports about any injuries from the overnight shift for Resident #119. Certified Nursing Aide #5 stated on 2/29/2024 at around 9:30 AM, they observed the bruises on the resident's arms while changing the resident's clothing. Certified Nursing Assistant #5 stated they always handled the resident gently and there was no incident before the bruising was identified. Certified Nursing Aide #5 stated they notified the unit nurse immediately. Certified Nursing Aide #5 stated they did not provide a written statement to the facility because no one asked them to. Certified Nursing Aide #5 stated they had reported the incident to Registered Nurse #5 and did not know why the incident report reflected that the incident happened at 3:00 PM. Resident #119 was observed on 3/4/2024 at 9:02 AM. Resident #119 was alert but not interviewable, a staff was next to the resident and was observed assisting the resident while they (Resident #119) ambulated on the unit. A dark purple area of discoloration on the right arm, approximately half the size of the palm of a hand was observed. The Risk Manager, who was also the facility's Infection Preventionist, was interviewed on 3/9/2024 at 1:00 PM. The Risk Manager stated they (Risk Manager) were responsible for reviewing the entire Accident and Incident report to determine if further investigation is required. The Risk Manager stated they were responsible for obtaining additional statements as needed to complete a thorough investigation. The Risk Manager stated that they would summarize the investigation once they reviewed all documentation and the report would then be submitted to the Administrator and the Director of Nursing Services for review. The Risk Manager stated the Administrator and the Director of Nursing Services will decide whether the accident/incident should be reported to the New York State Department of Health. The Administrator and the Director of Nursing Services were interviewed concurrently on 3/9/2024 at 3:41 PM and stated they both reviewed all the Accident and Incident reports after the investigation was completed to determine if the incidents should be reported to the New York State Department of Health. The Administrator and the Director of Nursing Services stated that all incidents of injuries of unknown origin must be reported to the New York State Department of Health. The Director of Nursing Services stated that all three incidents for Resident #119 were unwitnessed and the resident was unable to give an account of the causes of the injuries due to poor cognition. The Director of Nursing Services stated they believed there were known causes that explained how the resident could have sustained those injuries and therefore, the facility was not required to report the incidents to the New York State Department of Health. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10 NYCRR 415.4 (b)(2)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44963 Based on observations, record review and interviews conducted during a Recertification Survey initiated on 3/4/2024 and completed on 3/9/2024, the facility did not ensure that all alleged violations were thoroughly investigated in response to allegations of abuse, neglect, exploitation, and misappropriation of resident property, including injuries of unknown source. This was identified for one (Resident #119) of eight residents reviewed for Accidents. Specifically, Resident #119 with a diagnosis of Dementia and impaired cognition sustained the following unwitnessed injuries of unknown origin 1a) a laceration to the right arm which required transfer to the hospital and treatment of 16 staples on 12/6/2023, 1b) ecchymotic (bruise) area to the left buttock on 2/27/2024 and 1c) ecchymotic area to the left upper inner forearm and the right outer arm on 2/29/2024. Resident #119 was observed with injuries of unknown origin on three occasions. The facility did not thoroughly investigate the incidents to identify the root cause of the injuries and to rule out Abuse, Neglect, or Mistreatment. The findings are: The facility's policy titled, Abuse Prevention and Reporting last revised in January 2020 defined Injuries of Unknown Origin as when the source of the injury was not observed by any person, or the resident could not explain the source of the injury and the injury is suspicious because of the extent of the injury or the location of the injury. Under the section Investigation, the policy documented the nursing supervisor is to begin an investigation upon the identification of an incident or occurrence, to obtain all statements necessary to complete the investigation; and to report all allegations including injuries of unknown origin to the Administrator. Resident #119 was admitted with diagnoses including Dementia, Anxiety, and Lack of Coordination. The Quarterly Minimum Data Set assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 99 which indicated the resident was unable to complete the interview. The Minimum Data Set documented that Resident #119 was sometimes able to understand and be understood and did not exhibit behaviors of rejection of care or wandering. A Comprehensive Care Plan for Falls dated 6/9/2021 and last reviewed on 2/27/2024 documented the resident was at risk for falls/injuries secondary to a history of falls, psychotropic drug use, impaired vision, and Dementia. Interventions included to investigate the cause of the fall immediately and to ensure the use of proper footwear. The care plan interventions were updated on 12/18/2023 to include one to one monitoring at all times. 1a) An Accident and Incident Report dated 12/6/2023 at 9:30 PM documented Resident #119 was noted with a laceration to the right arm. The resident was unable to explain what happened. The location of the incident was unknown. A Certified Nursing Aide observed the resident with their (Resident #119) right arm bleeding. The Accident and Incident report was not signed by the nurse who initiated the incident report and also did not identify the Certified Nurse Aide who had initially reported the injury. (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A statement written by Certified Nursing Aide #2 dated 12/6/2023 documented that Certified Nursing Aide #2 was assigned to Resident #119 and saw Resident #119 around 5:30 PM in the hallway. Certified Nursing Aide #2 documented that the resident was seen eating dinner in the dining room around 5:50 PM. Certified Nursing Aide #2 documented they did not witness the incident or any environmental issue that may have contributed to the incident. The written statement did not indicate that Certified Nursing Aide #2 had observed Resident #119's right arm injury on 12/6/2023. A nursing progress note dated 12/7/2023 by Licensed Practical Nurse #3 documented that Licensed Practical Nurse #3 was called to the resident's room around 9:30 PM on 12/6/2023. Upon arrival, the resident was observed with a laceration of unknown origin to the right forearm. The resident was transferred to the hospital for possible sutures. The resident's physician was notified. The summary of the investigation dated 12/7/2023 documented that at 9:30 PM on Thursday 12/6/2023 (12/6/2023 was a Wednesday) Certified Nursing Aide #2 found Resident #119 in another resident's room with a large laceration on their (Resident #119) right forearm. Certified Nursing Aide #2 called for a nurse. Licensed Practical Nurse #3 came and applied pressure on the wound. A Physician was notified and the resident was transferred to the hospital. The investigation summary documented that when Resident #119 was found with the right-arm laceration, they (Resident #119) were standing with a piece of wood from the dresser in their hand and it was determined the resident scraped their arm with the piece of wood that resulted in a laceration. The investigation concluded that there was no cause to believe abuse, mistreatment, or neglect had occurred. The facility investigation did not include statements from the resident or the staff member who initially found the resident with the laceration. Furthermore, there were no statements from the resident or staff members who allegedly saw the resident holding a piece of wood that may have caused the laceration to the resident's right arm. Certified Nursing Aide #2 was interviewed on 3/8/2024 at 4:14 PM and stated that they were assigned to Resident #119 on 12/6/2023 during the evening shift. Certified Nursing Aide #2 stated they helped the resident during dinner time and last saw the resident around 6:00 PM. Certified Nursing Aide #2 stated they had dressed the resident before dinner and the resident did not have any injuries to their right arm. Certified Nursing Aide #2 stated they did not witness the resident sustaining the injury and were not the one who found the resident with the laceration. Certified Nursing Aide #2 stated they did not know how the resident got hurt. Certified Nursing Aide #3, who worked on the resident's unit on 12/6/2023 during the evening shift(3:00 PM-11:00 PM), was interviewed on 3/8/2024 at 5:23 PM and stated that they were not assigned to Resident #119 on 12/6/2023 and did not witness how Resident #119 sustained the injury to their arm and therefore did not report the incident regarding Resident #119. Certified Nursing Aide #3 did not recall if they were interviewed or asked to write a statement by the facility. Certified Nursing Aide #6, who worked on the resident's unit on 12/6/2023 during the evening shift (3:00 PM-11:00 PM), was interviewed on 3/8/2024 at 5:34 PM and stated that they were not assigned to Resident #119 on 12/6/2023 and did not witness how Resident #119 sustained the injury to their arm and therefore did not report the incident regarding Resident #119. Certified Nursing Aide #6 did not recall if they were interviewed or asked to write a statement by the facility. (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Certified Nursing Aide #7, who worked on the resident's unit on 12/6/2023 during the evening shift (3:00 PM-11:00 PM), was interviewed on 3/9/2024 at 12:10 PM and stated that they were not assigned to the resident on 12/6/2023 and did not witness how Resident #119 sustained the injury to their arm and therefore did not report the incident regarding Resident #119. Certified Nursing Aide #7 stated they were not interviewed or asked to write a statement by the facility. Licensed Practical Nurse #3 was interviewed on 3/9/2024 at 11:17 AM and stated that they responded to a call from Resident #119's unit on 12/6/2023 during the evening shift. Licensed Practical Nurse #3 stated when they arrived on the unit, they (Licensed Practical Nurse #3) saw Resident #119 with their long sleeve shirt removed by staff which revealed a deep laceration to the resident's arm and the resident was bleeding. Licensed Practical Nurse #3 stated they did not witness what happened and did not recall seeing any object in the resident's hand or surroundings. Licensed Practical Nurse #3 stated after they (Licensed Practical Nurse #3) arranged to send the resident to the hospital, they (Licensed Practical Nurse#3) and other unit staff conducted a room and unit search to look for any sharp objects such as knives that could potentially cause the injury. Licensed Practical Nurse #3 stated no sharp objects were found and they (Licensed Practical Nurse#3) observed no broken or damaged pieces of furniture. Licensed Practical Nurse #3 did not recall being asked to write a statement. The Risk Manager, who was also the facility's Infection Preventionist, was interviewed on 3/9/2024 at 1:00 PM. The Risk Manager stated they were responsible for reviewing all the Accident and Incident reports and determining if further investigation is required. The Risk Manager stated they were responsible for obtaining additional statements as needed to complete a thorough investigation. The Risk Manager stated that they would summarize the investigation once they reviewed all documentation; the report would then be submitted to the Administrator and the Director of Nursing Services for review. The Risk Manager stated there should be a statement from the staff who saw and reported the injury. The Risk Manager stated they (Risk Manager) also had information as to how they (Risk Manager) were able to conclude the resident was injured by a piece of broken drawer. The Risk Manager stated all documentation and statements obtained for this incident should have been filed away together and did not know why those statements were not attached to the Accident and Incident report. The Risk Manager stated they would look for the missing documents again in their office. The Risk Manager returned on 3/9/2024 at 2:46 PM with the statement of occurrence signed by Licensed Practical Nurse #3. The date of occurrence on the statement was documented as 12/6/2024 and was signed by Licensed Practical Nurse #3 on 12/7/2024. The statement documented that on 2/6/2024, Licensed Practical Nurse#3 was called to Resident #119's unit by a Certified Nursing Aide to find Resident #119 holding a piece of wood and Resident #119's right arm bleeding. The Risk Manager was immediately interviewed on 3/9/2024 about the inaccurate dates and stated they reviewed the statement at the time and did not notice the inaccurate dates (year 2024) on the statement. The Risk Manager stated they should have caught the error; however, they were just typographical errors. The Risk Manager stated they did not know why Licensed Practical Nurse #3 provided inconsistent information regarding the incident in their (Licensed Practical Nurse #3) nursing progress note, in the incident statement, and during the interview with the surveyor. (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensed Practical Nurse #3 was re-interviewed on 3/9/2024 at 3:09 PM and stated that someone wrote the statement and they (Licensed Practical Nurse #3) signed after reviewing what was written on December 7th. Licensed Practical Nurse #3 stated they were not aware that the date of occurrence was incorrect, and they were not aware that they (Licensed Practical Nurse #3) signed and also dated the document incorrectly. Licensed Practical Nurse #3 stated when they responded and went to the unit on 12/6/2023, the resident was already bleeding. Licensed Practical Nurse #3 stated they did not see that the resident was cut by a piece of wood. Licensed Practical Nurse #3 did not recall which Certified Nursing Aide saw the resident holding a piece of wood. 1b) An Accident and Incident Report dated 2/27/2024 documented Resident #119 was observed with an ecchymotic area to their left buttock. The resident was unable to state what happened secondary to impaired mental status. The location of the incident was unknown. The Registered Nurse assessment documented the resident was alert and responsive with confusion with no signs and symptoms of pain or discomfort. A statement written by Certified Nursing Aide #4 dated 2/27/2024 documented that Certified Nursing Aide #4 was assigned to Resident #119 and observed a purple bruise around Resident #119's left buttock during care. Certified Nursing Aide #4 documented they notified the nurse upon discovery. Certified Nursing Aide #4 documented that the incident was not witnessed by any personnel or visitor. The summary of the investigation dated 2/28/2024 documented that on Tuesday 2/27/2024 around 11:00 AM Certified Nursing Aide #4 was changing Resident #119's brief and noticed a bruise on the resident's left buttock. Resident #119 was on 1:1 supervision and had no falls or incidents of late. Upon investigation, the interdisciplinary team determined that the ecchymotic area on the resident's left buttock could be from their buttock hitting against the arm of a stationary chair and/or the bench in the unit dining room as the resident was attempting to sit. The resident is up and down in chairs in their room and the unit dining room all day with a 1:1 staff member by their side. At times the resident needed assistance and redirection with sitting and standing. The investigation concluded that there was no cause to believe abuse, mistreatment, or neglect had occurred. The Accident and Incident report or the Investigation Summary did not include statements from the staff from the previous shifts to determine the root cause of the injury of unknown origin. Certified Nursing Aide #8, who was assigned to Resident #119 during the day shift (7:00 AM-3:00 PM) on 2/27/2024, was interviewed on 3/8/2024 at 1:52 PM. Certified Nursing Aide #8 stated was Certified Nursing Aide #4 was assigned to Resident #119 for one to one monitoring and was also providing care to the resident on 2/27/2024. Certified Nursing Aide #8 stated they (Certified Nursing Aide #8) did not provide any care to the resident or notice anything prior to the discovery of the discoloration to the resident's buttock area. Certified Nursing Aide #8 stated they were not interviewed by the facility after the incident was reported. (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Risk Manager, who was also the facility's Infection Preventionist, was interviewed on 3/9/2024 at 1:00 PM. The Risk Manager stated Resident #119 was not able to explain the bruise and the incident was unwitnessed. The Risk Manager stated there were no falls or incidents reported prior to the discovery of the bruising to the buttock area. The Risk Manager stated that Resident #119 was likely sitting too hard onto the chairs which caused the bruising. The Risk Manager stated there could be pending statements in their office for this incident because the incident was recent. The Risk Manager returned at 3:24 PM and stated there were no additional statements found because there was no need for additional statements. 1c) An Accident and Incident Report dated 2/29/2024 documented on 2/29/2024 at 3:00 PM, Resident #119 was observed with an ecchymotic area to their right outer arm near the armpit and to their left upper inner forearm. The resident was unable to explain the cause of the injuries due to cognitive impairment. The location of the incident was documented as unknown. The Registered Nurse assessment documented a visible ecchymotic area on both left and right arms, there was no swelling observed. The Accident and Incident report was not signed by the staff member who completed the report. A verbal statement obtained by the facility from Certified Nursing Aide #5 dated 2/29/2024 documented that Certified Nursing Aide #5 was assigned to Resident #119 and observed bruises while changing the resident. The resident did not fall while they were with Certified Nursing Aide #5. The summary of the investigation dated 3/1/2024 documented that on Thursday 2/29/2024 Certified Nursing Aide (not identified in the summary) was providing care and noticed slightly reddened/ecchymotic areas on the resident's left and right upper arms. The resident had no falls or incidents and remained on 1:1 supervision for safety. The summary concluded that if the resident pulled away quickly while a staff member was redirecting or guiding the resident by gently holding the resident, the resident could possibly injure their fragile skin which caused purpura or ecchymosis. The investigation concluded that there was no cause to believe abuse, mistreatment, or neglect had occurred. The Accident and Incident report or the Investigation Summary did not include statements from the staff from the previous shifts to determine the root cause of the injuries of unknown origin. Certified Nursing Aide #5 was interviewed on 3/8/2024 at 2:29 PM and stated that they were the assigned 1:1 staff for Resident #119 on 2/29/2024. Certified Nursing Aide #5 stated that they did not receive reports about any injuries from the overnight shift for Resident #119. Certified Nursing Aide #5 stated on 2/29/2024 at around 9:30 AM, they observed the bruises on the resident's arms while changing the resident's clothing. Certified Nursing Assistant #5 stated they always handled the resident gently and there was no incident before the bruising was identified. Certified Nursing Aide #5 stated they notified the unit nurse immediately. Certified Nursing Aide #5 stated they did not provide a written statement to the facility because no one asked them to. Certified Nursing Aide #5 stated they had reported the incident to Registered Nurse #5 and did not know why the incident report reflected that the incident happened at 3:00 PM. (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered Nurse #5, who was the unit charge nurse, was interviewed on 3/8/2024 at 3:27 PM and stated there was no report from the previous night (2/28/2024) shift regarding Resident #119. Registered Nurse #5 stated around 9:30 AM on 2/29/2024, Certified Nursing Aide #5 notified them (Registered Nurse #5) about the bruises on the resident's arm. Registered Nurse #5 stated they assessed the resident and notified the resident's Physician and family. Registered Nurse #5 stated they initiated an incident report and acknowledged the time of notification was documented incorrectly. Registered Nurse #5 stated they had likely documented the time they were writing the report and not the actual time the calls were made. Registered Nurse #5 stated they were not asked to write a statement as their nursing assessment on the report is considered part of their statement. Registered Nurse #5 stated they documented their findings in the progress note. A nursing progress note written by Registered Nurse #5 on 2/29/2024 at 3:43 PM documented an ecchymotic area to the right outer arm near the armpit and to the left upper inner forearm. There was no swelling. The progress note was not included or attached to the Accident and Incident report. The Risk Manager was interviewed on 3/9/2024 at 1:00 PM and stated Resident #119 was not able to explain how they sustained the bruising. The Risk Manager stated that the resident's bruises were unwitnessed and therefore the origin of the bruising was not known. The Risk Manager stated there could be pending statements in their office for this incident because the incident was recent. The Risk Manager returned at 3:24 PM and stated there were no additional statements found because there was no need for additional statements. Resident #119 was observed on 3/4/2024 at 9:02 AM. Resident #119 was alert but not interviewable, a staff member was next to the resident and was observed assisting the resident while they (Resident #119) ambulated on the unit. A dark purple area of discoloration on the right arm, approximately half the size of the palm, of a hand was observed. The Administrator and the Director of Nursing Services were interviewed concurrently on 3/9/2024 at 3:41 PM and both stated the Risk Manager should ensure all Accident and Incident reports are reviewed and investigated thoroughly. The Director of Nursing Services stated that the Risk Manager should ensure all data and information in the reports were completed accurately and correctly. The Administrator stated that there is room to improve regarding how the investigations are conducted. 10 NYCRR 415.4 (b)(3)		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41051 Based on record review and interviews during the Recertification Survey initiated on 3/4/2024 and completed on 3/9/2024 the facility did not ensure that a Baseline Care Plan for each resident was developed that included the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care within 48 hours of admission. This was identified for one (Resident #78) of four residents reviewed for skin conditions. Specifically, Resident #78 was admitted with impaired skin integrity, and a baseline care plan was not developed within 48 hours of the resident's admission. The finding is: The facility's policy titled, Care Planning last revised 1/2022 documented that upon admission the baseline care plan will be initiated and completed within 48 hours as per the Centers for Medicare & Medicaid Services guidelines. Resident #78 was admitted with diagnoses that included Alzheimer's Disease, Parkinson's Disease, and a Stage 1 Sacral Pressure Ulcer. The Admission Minimum Data Set assessment dated [DATE] documented the resident's Brief Interview for Mental Status score was 99 indicating the resident was unable to complete the interview. The Minimum Data Set assessment documented Resident #78 was at risk for developing Pressure Ulcers and had one unhealed, Stage 2 Pressure Ulcer on admission. The Minimum Data Set assessment documented Resident #78 was dependent on staff for bed mobility and transfer. The Minimum Data Set assessment documented Resident #78 was always incontinent of bladder and frequently incontinent of bowel. Resident #78's Admission Nursing Evaluation completed on 1/5/2024 documented Resident #78 had a Stage 1 Sacral Pressure Ulcer which measured 3 centimeters long x 3 centimeters wide x 0 centimeters deep and a Braden scale (an assessment tool for predicting the risk of pressure ulcer development) score of 17 which indicated a mild risk for pressure ulcer development. Resident #78's Baseline Care Plan created on 1/4/2024 did not document Resident #78 had a Pressure Ulcer. The intervention section for skin breakdown was not completed. A wound care initial evaluation completed on 1/8/2024 documented the sacral wound as a Stage 2 Pressure Ulcer which measured 1.5 centimeters long x 1.5 centimeters wide x 0.1 centimeters deep. A Comprehensive Care Plan for Skin Integrity dated 1/8/2024 documented Resident #78 had a Stage 2 Sacral Pressure Ulcer. Interventions included but were not limited to the provision of wound care consults, treatments as ordered, skin assessment on every shift, and incontinence care every shift and as needed. Registered Nurse #7, the unit Charge Nurse, was interviewed on 3/7/2024 at 3:56 PM and stated the Baseline Care Plan was completed by the admission nurse. A Baseline Care Plan for Skin Integrity is completed for every resident at admission and should have been completed for Resident #78 due to the presence of a Pressure Ulcer upon admission. (continued on next page)		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Director of Nursing Services was interviewed on 3/9/2024 at 12:16 PM. The Director of Nursing Services stated a Baseline Care Plan for Skin Integrity should have been put in place for Resident #78 due to the presence of a Pressure Ulcer at the time of admission. 10 NYCRR 415.11		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41051 Based on observations, record review, and interviews during the Recertification Survey initiated on 3/4/2024 and completed on 3/9/2024 the facility did not ensure each resident's Comprehensive Care Plan was reviewed and revised to reflect the current needs of each resident. This was identified for one (Resident #78) of three residents reviewed for pressure ulcers and one (Resident #171) of two residents reviewed for edema. Specifically, 1) Resident #78's Comprehensive Care Plan was not updated to reflect the resident's use of the heel off-loading medical surgical shoe or offloading the heels; and 2) Resident #171's Comprehensive Care Plan was not updated to reflect the use of lower leg compression wraps to treat bilateral lower leg edema (swelling caused by too much fluid trapped in the body's tissues). The findings are: The facility's policy, titled Care Planning, last reviewed in January 2022, documented care planning will be implemented through the integration of assessment findings, consideration of the prescribed treatment plan, and development of goals for the resident that are reasonable and measurable. The plan of care shall be individualized, based on diagnosis, resident assessment, and the personal goals of the resident and their family. Care planning is based on data collected from resident assessments with the integration of those assessment findings into the care planning process. 1) Resident #78 was admitted with diagnoses that included Alzheimer's Disease, Parkinson's Disease, and a Stage 1 Sacral Pressure Ulcer. The Admission Minimum Data Set assessment dated [DATE] documented the resident's Brief Interview for Mental Status score was 99 indicating the resident was unable to complete the interview. The Minimum Data Set assessment documented Resident #78 was at risk for developing Pressure Ulcers and had one unhealed Stage 2 Pressure Ulcer on admission. A Nursing Progress Note, written by Licensed Practical Nurse #5, dated 2/3/2024 documented Resident #78 was noted with an intact blister on their right heel. The treatment to cleanse the area with normal saline solution and application of a conventional daily dressing once a day was in place. The doctor and resident representative were made aware and the wound care team was to follow up on 2/5/2024. The progress note documented to use of the heel off-loading medical surgical shoe that was provided by the Physical Therapy department. A wound care assessment dated [DATE] documented a Deep Tissue Injury to Resident #78's sacrum which measured 1.5 centimeters long x 1.5 centimeters wide x 0 centimeters deep; a fluid-filled blister to the right heel which measured 6 centimeters long x 6 centimeters wide x 0 centimeters deep; and blanching erythema (first clinical sign of a pressure ulcer) to the left heel. Recommendations were made to offload heels with pillows and to utilize an air mattress. A Skin Integrity Care Plan for Right Heel Stage 3 effective 2/12/2024 documented an intervention of heel booties in bed that was not added until 3/6/2024. A Skin Integrity Care Plan for a Left Heel Deep Tissue Injury was initiated on 2/27/2024. The Care Plan did not include any intervention to offload heels. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #78 was observed on 3/6/2024 at 11:28 AM in the dining area. Resident #78 was observed in their wheelchair with heel booties on both feet. Registered Nurse #7 was interviewed on 3/7/2024 at 3:56 PM. Registered Nurse #7 stated there should be an order for heel off-loading medical surgical shoes. Physical Therapy Assistant #1 was interviewed on 3/8/2024 at 3:08 PM. Physical Therapy Assistant #1 stated they provided the heel off-loading medical surgical shoe for Resident #78 to Licensed Practical Nurse #5 on 2/3/2024. Physical Therapy Assistant #1 stated they spoke to the Wound Care Nurse and the Wound Care Nurse recommended the heel off-loading medical surgical shoe, but they (Physical Therapy Assistant #1) did not document the conversation. Certified Nursing Assistant #12 was interviewed on 3/8/2024 at 3:37 PM. Certified Nursing Assistant #12 stated they informed the nurse (could not recall which nurse or exact date) that Resident #78 had a blister on their right heel. Certified Nursing Assistant #12 stated they do not document anything regarding heel off-loading medical surgical shoes on the Certified Nursing Assistant Accountability. Certified Nursing Assistant #12 stated they saw Resident #78 with the off-loading medical surgical shoe on and just continued to put them on so that their (Resident #78's) pressure ulcer did not get worse. Licensed Practical Nurse #5 was interviewed on 3/9/2024 at 9:11 AM. Licensed Practical Nurse #5 stated they wrote the Nursing Progress Note on 2/3/2024 regarding the blister on Resident #78's right heel. Licensed Practical Nurse #5 stated Physician #2 told them (Licensed Practical Nurse #5) to get a heel off-loading medical surgical shoe for Resident #78. Licensed Practical Nurse #5 stated the wound care team was to follow up on 2/5/2024 and they did not know why the blister on the right heel was not assessed by the wound care team until 2/12/2024. Licensed Practical Nurse #5 stated they should have entered a consultation order for wound care on 2/5/2024 into the electronic medical record but they must have forgotten to do so. Licensed Practical Nurse #5 stated there is a binder at the unit's nurse's station where consultations for wound care are placed. Licensed Practical Nurse #5 stated they recalled placing Resident #78's face sheet and a note regarding the blister on the right heel in the binder and did not know why the resident was not seen by the wound care team on 2/5/2024. Licensed Practical Nurse #5 stated they should have updated the Skin Integrity Comprehensive Care Plan to include the heel off-loading medical surgical shoe. Registered Nurse #2 was interviewed on 3/9/2024 at 11:04 AM. Registered Nurse #2 stated Licensed Practical Nurse #5 should have updated the Comprehensive Care Plan once they received the telephone order for the heel offloading medical surgical shoe from the doctor. If Licensed Practical Nurse #5 was not able to update the Comprehensive Care Plan they should have notified the Charge Nurse. Registered Nurse #2 stated a physician's order for the heel offloading medical surgical shoe also should have been placed in the electronic medical record. The Director of Nursing Services was interviewed on 3/9/2024 at 12:16 PM. The Director of Nursing Services stated the heel off-loading medical surgical shoe should have an order from the wound care doctor. The Director of Nursing Services stated Licensed Practical Nurse #5 should have placed an order in the electronic medical record for Resident #78 to be seen by the wound care team (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Wound Care Nurse was interviewed on 3/9/2024 at 12:42 PM. The Wound Care Nurse stated they do not recall talking to Physical Therapy Assistant #1 regarding Resident #78. The Wound Care Nurse stated they would not direct a heel off-loading medical surgical shoe to be put in place. The Wound Care Nurse stated a recommendation would come from the Wound Care Nurse Practitioner and the Medical Doctor would make the final decision. The Wound Care Nurse stated they did not receive a referral to see Resident #78 on 2/5/2024. The Wound Care Nurse Practitioner was interviewed on 3/9/2024 at 4:07 PM. The Wound Care Nurse Practitioner stated they completed wound care rounds with the Wound Care Nurse on 2/5/2024 and the Wound Care Nurse set up who they (the Wound Care Nurse Practitioner) had to see. The Wound Care Nurse Practitioner stated they did not see Resident #78 on 2/5/2024. 2) Resident #171 was admitted with diagnoses that included Multiple Rib Fractures, Vascular Dementia, and Hypertension. Resident #171's Admission Minimum Data Set assessment dated [DATE] documented the resident's Brief Interview for Mental Status score was 7 which indicated the resident had severe cognitive impairment. Resident #171 was on a therapeutic, no added sodium diet. A physician's order dated 2/1/2024 documented to apply compression wraps on every morning and off every evening. The order did not indicate where to apply the compression wraps. Resident #171 was observed on 3/4/2024 at 9:28 AM. Resident #171's both lower legs appeared swollen and no compression wraps were observed on Resident #171's lower legs. Resident #171 was interviewed on 3/4/2024 at 9:28 AM and stated they do not feel like their legs are any less swollen than they were in January of 2024. Resident #171 was observed on 3/5/2024 at 12:22 PM. Compression wraps were present on both lower legs. A Cardiovascular Care Plan initiated on 1/11/2024 documented the resident was at risk for cardiovascular dysfunction secondary to Congestive Heart Failure, Hypertension, and High Cholesterol. Interventions included but were not limited to, monitor for edema and administer medications as prescribed by the medical doctor. The care plan was updated on 1/31/2024 and documented the resident had bilateral lower extremity edema. The comprehensive care plan was not updated to include the physician-ordered compression wraps for the lower extremities. Registered Nurse #8 was interviewed on 3/8/2024 at 4:03 PM and stated care plans are initiated by any Registered Nurse on the unit or the Registered Nurse Supervisor. Any Licensed Practical Nurse can also update a care plan. Registered Nurse #2, a Registered Nurse Supervisor, was interviewed on 3/9/2024 at 11:20 AM. Registered Nurse #2 stated the care plans for Resident #171 should have been updated when the compression wraps were ordered. The Director of Nursing Services was interviewed on 3/9/2024 at 12:28 PM and stated the care plans for Resident #171 should have been updated when the compression wraps were ordered. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician Assistant #1 was interviewed on 3/9/2024 at 2:19 PM. Physician Assistant #1 stated they asked Licensed Practical Nurse #5 to order bilateral compression wraps for Resident #171 on 2/1/2024 after they (Physician Assistant #1) examined Resident #171. An attempt was made to interview Licensed Practical Nurse #5 on 3/9/2024 at 2:17 PM but they were not available. 10 NYCRR 415.11(c)(2)(i-iii)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28670 Based on observation, record review and staff interviews during the Recertification Survey initiated on 3/4/2024 and completed on 3/9/2024, the facility did not ensure that services provided or arranged by the facility outlined by the comprehensive plan of care meet professional standards of care. This was identified for one (Resident #169) of eight residents reviewed for medication administration. Specifically, during a medication pass observation on 3/6/2024 at 6:25 AM for Resident #169, Registered Nurse #4 removed a Levothyroxine (medication used to treat underactive thyroid gland) 50 micrograms tablet from a blister pack that had Resident #49's identification label and then administered the medication to Resident #169. The finding is: The facility Medication Administration policy and procedure updated 11/2023 documented medications are administered to residents in a timely and accurate manner by a Licensed nurse who compares the medication name, strength, and dosage schedule on the medication administration record against the prescription label. Resident #169 was admitted with Hypothyroidism and Hypertension. A Minimum Data Set assessment dated [DATE] documented the resident's Brief Interview for Mental Status score was 14 which indicated the resident had intact cognition. A Physician's order dated 1/26/2024 and renewed on 2/23/2024 documented to administer Levothyroxine 50 micrograms one tablet via oral route once daily at 6:00 AM. A medication pass observation was conducted on 3/6/2024 at 6:25 AM for Resident #169. Registered Nurse #4 was unable to locate a Levothyroxine 50 microgram tablet for Resident #169 and was observed to remove a Levothyroxine 50 microgram tablet from another blister pack that had Resident # 49's identification label and then administered the Levothyroxine 50 microgram to Resident #169. Registered Nurse #4 was interviewed on 3/6/2024 at 6:30 AM and stated that they ran out of the Levothyroxine medication and needed to reorder the medication from the pharmacy for a refill for Resident #169. Registered Nurse #4 stated that they were not the regularly assigned nurse for Resident #169. Registered Nurse #4 stated that the medication should have been reordered when there were 3 to 4 pills left in the blister pack. Registered Nurse #4 stated when they run out of medication, they either borrow medication from another resident, from the blister pack of a resident who was discharged , or from another unit. Registered Nurse #4 stated they were aware they should not borrow the medications from one resident to administer to another resident. Registered Nurse #4 stated that they borrowed the Levothyroxine tablet because it was an important medication and that they did not want Resident #169 to miss their medication. Registered Nurse #6, who was the Nursing Supervisor on the 11:00-7:00 AM shift, was interviewed on 3/6/2024 at 6:45 AM. Registered Nurse #6 stated if a nurse ran out of a critical medication like Eliquis (blood thinner), they were allowed to borrow the medication from another resident. Registered Nurse #6 stated Levothyroxine was not a critical medication and that the nurse should not have borrowed the medication to administer it to Resident #169. (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Director of Nursing Services was interviewed on 3/6/2024 at 7:45 AM and stated that the nurses should absolutely not be borrowing medication from one resident to administer to another resident. The Director of Nursing Services stated that there should not be any occasion where the resident medication should run out. The Director of Nursing Services stated that there is no policy for borrowing medication. 10 NYCRR 415.11(c)(3)(i)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28670 Based on observation, record review, and interviews during the Recertification Survey initiated on 3/4/2024 and completed on 3/9/2024, the facility did not ensure that a resident who is unable to carry out activities of daily living receives the necessary services to maintain good grooming and personal hygiene. This was identified for one (Resident #56) of three residents reviewed for activities of daily living. Specifically, on 3/4/2024 and 3/7/2024 Resident #56 was observed with long fingernails to both hands. The resident's right-hand fingernails were resting on the resident's palm and a brown substance was observed under the nails of the left hand. The finding is: The facility's undated policy and procedure for Fingernails and Toenails Care documented nail care includes daily cleaning and regular trimming, and to trim and smooth the resident's nails to prevent the resident from accidentally scratching their skin. Resident#56 was admitted with diagnoses that included Right-hand contracture and Generalized Osteoarthritis. The Minimum Data Set assessment dated [DATE] documented the resident's Brief Interview for Mental Status score was 11 which indicated the resident had moderate cognitive impairment. The resident had functional limitations in bilateral upper and lower extremities and required moderate assistance for personal hygiene. Resident #56 was observed lying in bed on 3/4/2024 at 11:30 AM. The resident's left-hand fingernails were long with a brown substance under the nails. The resident's right hand was observed with long fingernails which were resting on the resident's palm. Resident #56 was observed sitting in a wheelchair in their room on 3/7/24 at 12:10 PM. The resident's fingernails were long on both hands and there was a brown substance under the left hand fingernails. The right-hand fingernails were resting on the resident's palm. The Comprehensive Care Plan for Activities of Daily Living dated 4/19/2017 and last updated on 12/19/2023 documented that the resident required assistance with all activities of daily living. The Comprehensive Care Plan documented the resident required extensive assistance for Personal Hygiene. A Comprehensive Care Plan for Skin Integrity dated 4/19/2017 and last updated 12/19/2023 documented to keep the resident's fingernails trimmed. A Physician's order dated 12/19/2023 and updated 2/24/2024 documented to keep the resident's fingernails trimmed. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Certified Nursing Assistant #10 was interviewed on 3/7/2024 at 2:50 PM. Certified Nursing Assistant #10 stated they were not the regularly assigned Certified Nursing Assistant for Resident #56. An observation of the resident's nails was made by Certified Nursing Assistant #10 during the interview, and they stated that the resident's nails needed to be trimmed and cleaned. Certified Nursing Assistant #10 stated the resident's nails are usually trimmed on shower days and as needed by the Certified Nursing Assistant who showers the resident. Certified Nursing Assistant #10 stated that they were also responsible for trimming and cleaning the resident's nails as needed during care of the resident. In a subsequent interview with Certified Nursing Assistant #10 on 3/9/2024 at 1:57 PM they stated they were supposed to clean the resident's nails during daily care. Certified Nursing Assistant #10 stated that they cleaned between the resident's fingers but did not pay attention to the resident nails. Certified Nursing Assistant #10 stated that they should have ensured that the resident's nails were clean. Registered Nurse #3, who was the unit Manager, was interviewed on 3/7/24 at 3:20 PM and stated the Certified Nursing Assistants were responsible for clipping the resident's nails on shower days and as needed. Registered Nurse #3 stated that nail clippers were available for the Certified Nursing Assistants to trim and clean the resident's fingernails. Registered Nurse #3 stated the regularly assigned Certified Nursing Assistant was on vacation and that the Certified Nursing Assistants who were caring for the resident were responsible for clipping and cleaning the resident's nails. Registered Nurse #3 further stated there was no excuse for the resident's nails not to be cleaned and trimmed. The Director of Nursing Services was interviewed on 3/8/2024 at 3:29 PM and stated that the Certified Nursing Assistant who cares for the resident was responsible for the clipping and cleaning of the resident's nails on shower days. The Director of Nursing Services stated that if the resident's nails were not clipped on shower days the Certified Nursing Assistant that performed daily care for the resident should have completed that task. The Director of Nursing Services stated the expectation is for the resident's nails to be trimmed and cleaned by their caregivers irrespective of shower days or not. 10 NYCRR415.12(a)(3)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28670 Based on observations, record review, and interviews during the Recertification Survey initiated on 3/4/2024 and completed on 3/9/2024, the facility did not ensure that a resident with limited range of motion receives appropriate treatment and services to prevent further decrease in range of motion. This was identified for two (Resident #56 and Resident #36) of three residents reviewed for position/mobility. Specifically, Resident #56 and Resident #36 had a Physician's order for a hand roll to be worn at all times. On multiple occasions, Resident #56 and Resident #36 were observed not wearing the physician-ordered hand rolls. The findings are: The facility policy and procedure titled Physician Visits and Medical Orders dated 6/16/2021 documented that members of the interdisciplinary team shall provide care, services, and treatment according to the most recent medical orders. The facility policy and procedure titled, Quality of Care dated 12/2021, documented nursing services based on the comprehensive assessment of each resident will ensure that any resident who enters the facility with limited Range of Motion receives necessary treatment and services to promote an increase in Range of Motion and/or to prevent further decrease in Range of Motion, except as an unavoidable consequence of the resident's clinical condition. 1) Resident #56 was admitted with diagnoses that included right-hand contracture and Generalized Osteoarthritis. The Minimum Data Set assessment dated [DATE] documented the resident's Brief Interview for Mental Status score was 11 which indicated the resident had moderate cognitive impairment. The resident had functional limitations to bilateral upper and lower extremities and was receiving both Physical and Occupational Therapy services 5 days a week for 300 minutes. A Comprehensive Care Plan dated 4/19/2017 and last updated 12/19/2023 documented the resident was at risk for impaired skin integrity. Interventions included to apply a hand roll to the palm to offload pressure from the resident's fingernails and to assess the resident's skin every shift. A Physician's order dated 12/19/2023 and updated 2/24/2024 documented to apply a gauze roll to the right hand; to be worn at all times and removed for nursing care, hygiene, and skin checks. Resident #56 was observed lying in bed on 3/4/2024 at 11:30 AM. The resident's right hand was observed to be in a closed-fisted position and the resident was not able to open their hand on command. There was no gauze hand roll observed in the resident's right hand. Resident #56 was observed on 3/05/2024 at 12:18 PM sitting in the unit dining room. The resident was not wearing their right-hand gauze hand roll. Resident #56 was observed in their room sitting in a wheelchair on 3/7/2024 at 12:10 PM. The resident was not wearing their right-hand gauze hand roll. (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Certified Nursing Assistant #10 was interviewed on 3/7/2024 at 2:50 PM. Certified Nursing Assistant #10 stated that they were not aware that the resident was supposed to have a hand roll as they do not always care for the resident. Certified Nursing Assistant #10 stated that the care of the resident is documented in the Certified Nursing Assistant Accountability Task which is to be reviewed every shift. The Certified Nursing Assistant Accountability Task was reviewed with Certified Nursing Assistant #10 and revealed that the accountability record documented the use of the right-hand roll to be applied at all times. Licensed Practical Nurse #4, who was the medication nurse on 3/4/2024 and 3/5/2024, was interviewed on 3/7/2024 at 3:06 PM. Licensed Practical Nurse #4 stated that they were responsible for applying the hand roll to the resident's right hand and that generally, they do apply the hand roll but they were busy and forgot. Licensed Practical Nurse #4 stated that the hand roll should have been applied to the resident's right hand as ordered by the Physician. Registered Nurse #3, who was the Unit Manager, was interviewed on 3/7/2024 at 3:15 PM. Registered Nurse #3 stated that the medication nurses were responsible for applying the hand roll to the resident's hand. Registered Nurse #3 stated that if there was a Physician's order in place for a device the expectation was for staff to apply the device as ordered by the Physician. Physician #2, who was the resident's assigned Physician, was interviewed on 3/9/2024 at 10:44 AM. The Physician stated that the hand roll should be in place as ordered. The Physician stated that failure to apply the hand roll can lead to skin breakdown, especially if the resident's nails were not trimmed. Physical Therapist #1 was interviewed on 3/9/2024 at 11:37 AM. Physical Therapist #1 stated that the Occupational Therapist was responsible for recommending the hand gauze roll for Resident #56 due to the contracture(s) of the right hand. Physical Therapist #1 stated that it was important for the resident to wear the hand roll, as failure to wear the device can cause skin breakdown. 2) Resident #36 was admitted with diagnoses that included Vascular Dementia and right-hand contracture. A Significant Change Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 2 which indicated the resident had severely impaired cognition. The resident was dependent on staff for all areas of Activities of Daily Living. A Physician's order dated 1/23/2024 documented to apply a right-hand gauze roll, to be worn at all times. Remove for nursing care, hygiene, and skin checks. Resident #36 was observed on 3/5/2024 at 12:30 PM in the unit dining room during a lunch meal observation. The resident's right hand was tightly closed. There was no hand roll observed. Resident #36 was observed on 3/7/2024 at 2:57 PM in the unit dining room. The resident was not wearing a hand roll to the right hand. A Comprehensive Care Plan for Functional Abilities Self Care Mobility dated 1/5/2024 and last updated 3/6/2024 documented to apply a right-hand gauze roll, to be worn at all times. Remove for nursing care, skin check/hygiene, and report any changes to the Physician. (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Certified Nursing Assistant #11 was interviewed on 3/7/2024 at 3:00 PM. Certified Nursing Assistant #11 stated they were made aware that the resident should have a hand roll to the right hand; however, when they attempted to put the hand roll in place, the resident began to cry. Certified Nursing Assistant #11 stated they have reported difficulty getting the hand roll in place to the charge nurse. Licensed Practical Nurse #2, who was the medication nurse, was interviewed on 3/7/2024 at 3:10 PM. Licensed Practical Nurse #2 stated that at the start of their 7:00 AM-3:00 PM shift, they had applied the resident's hand roll; however, it might have fallen out during care. Licensed Practical Nurse #2 stated the Certified Nursing Assistant should have reported to them if the hand roll was not in place because the hand roll should be in place as ordered by the Physician. Registered Nurse #3, who was the Unit Manager, was interviewed on 3/7/2024 at 3:15 PM. Registered Nurse #3 stated that the nurses were responsible for applying the hand roll; however, the task can be delegated to the Certified Nursing Assistants. Registered Nurse #3 stated the resident's hand roll should have been in place as ordered by the Physician. The Director of Nursing Services was interviewed on 3/8/2024 at 3:11 PM. The Director of Nursing Services stated that the medication nurse and or the charge nurse were responsible for applying the hand roll to the resident's hand. The Director of Nursing Services stated that the hand roll should have been applied as ordered by the Physician. Physician #2, who was the resident's assigned Physician, was interviewed on 3/9/2024 at 10:44 AM. The Physician stated that the hand roll should be in place as ordered. The Physician stated that failure to apply the hand roll can lead to skin break down especially if the resident's nail was not trimmed. Physical Therapist #1 was interviewed on 3/9/2024 at 11:37 AM. Physical Therapist #1 stated that the Occupational Therapist was responsible for recommending the hand gauze roll for Resident #36 due to contracture(s) of the right hand. Physical Therapist #1 stated that it was important for the resident to wear the hand roll, as failure to wear the device can cause skin breakdown. 10 NYCRR 415.12(e)(2)		

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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** 48827 Based on observations, record review and interviews conducted during the Recertification Survey initiated on 3/04/2024 and completed on 3/09/2024, the facility did not ensure that each resident's environment remains as free of accident hazards as possible. This was identified for one (Resident # 167) of three residents reviewed for Accidents. Specifically, Resident #167 was not assessed to safely self-administer medications. During multiple observations on 3/04/2024 at 8:48 AM, 3/04/2024 at 11:13 AM, and again on 3/05/2024 at 8:38 AM. Resident #167 was observed with Physician-ordered medication in their room with no staff member in the vicinity. The finding is: The facility policy titled, Medication Administration dated 11/2023 documented that the Nurse ensures medications are not left unattended and to keep medications secured in a locked area or are visible at all times. The facility policy titled, Self Administration of Medications dated 11/2022 documented that residents who desire to self-administer their medications will be permitted to do so after appropriate counseling/teaching and with the specific order from the resident's Physician. Resident #167 was admitted with diagnoses including Chronic Kidney Failure, Cirrhosis of the Liver, and Hypokalemia (low potassium level). A Minimum Data Set assessment dated [DATE] documented the resident had a Brief Interview for Mental Status score of 14 which indicated the resident had intact cognition. The Comprehensive Care Plan dated 1/13/2024 and last reviewed on 2/28/2024 titled Functional Abilities: Self Care and Mobility, documented the resident required maximum assistance from a staff member for putting on and taking off footwear (the helper does more than half the effort). A Physician's order dated 1/27/2024 and renewed on 3/04/2024 documented to apply Ammonium Lactate 12% lotion (used to treat dry itchy skin) two times a day by topical route bilaterally to feet. Resident #167 was observed on 3/04/2024 at 8:48 AM, 3/04/2024 at 11:13 AM, and again on 3/05/2024 at 8:38 AM with Ammonium Lactate 12% lotion on the over-bed table. There was no staff member in the vicinity during each observation. Resident #167 was interviewed on 3/04/2024 at 11:13 AM and stated they have scabs on their feet and lower legs and they need the lotion. Resident #167 stated they usually apply the lotion to their feet and sometimes the nurse helps them. Resident #167 stated they cannot always reach their feet. Resident #167 was re-interviewed on 3/07/2024 at 8:53 AM and stated they put the Ammonium Lactate 12% lotion on their arms when they felt it was needed. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensed Practical Nurse #1 was interviewed on 3/07/2024 at 8:59 AM and stated Resident #167 did not have a physician's order to self-administer their medications including Ammonium Lactate 12% lotion. This resident can not reach their own feet and need the nurse to apply the lotion. Licensed Practical Nurse #1 stated that the resident did not have a physician's order to apply Ammonium Lactate lotion to their arms or legs; the order was to apply the medication just to their feet bilaterally twice a day. Licensed Practical Nurse #1 stated that the resident should have been evaluated by their Physician for self-administration of medications including applying the Ammonium Lactate lotion. Register Nurse Supervisor #1 was interviewed on 3/07/2024 at 9:09 AM and stated there was no order for Resident #167 to self-apply Ammonium Lactate 12% lotion or any other medication. The Ammonium Lactate 12% lotion is ordered for the resident's feet bilaterally twice a day. Register Nurse Supervisor #1 stated that Resident #167 was not evaluated to self-administer their medications. Register Nurse Supervisor #1 stated that Ammonium Lactate 12% lotion should be stored in the treatment cart and not in the resident's room. For the resident to self-administer a medication they would need to be evaluated and be able to give a return demonstration to ensure safety. The Director of Nursing Services was interviewed on 03/07/2024 at 2:36 PM and stated the Ammonium Lactate 12% lotion should not have been left at the bedside of this resident. The Ammonium Lactate 12% lotion should be kept in the treatment cart. If a resident wants to self-administer, we will reach out to the Physician to see if the resident can administer the medication. The resident would need to be evaluated by an Occupational Therapist and then obtain a Physician's order to self-apply. Pharmacist #1 was interviewed on 3/08/2024 at 11:42 AM and stated Ammonium Lactate 12% lotion can irritate the skin if used in excess. Physician #1 was interviewed on 3/09/2024 at 9:30 AM and stated the nurses are expected to follow the written orders and have a thin layer of the Ammonium Lactate 12% lotion applied to the resident's feet bilaterally to prevent ulcers and dry skin. Physician #1 stated if Ammonium Lactate 12% lotion is not applied correctly it can cause irritation, dry skin, and further complications. Physician #1 stated that Ammonium Lactate 12% lotion should not be applied to open wounds as it can irritate the open skin. 10 NYCRR 415.12(h)(1)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28670 Based on observation, record review, and staff interviews during the Recertification Survey initiated on 3/4/2024 and completed on 3/9/2024, the facility did not ensure that all nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs. This was identified for one (Resident #20) of two residents reviewed for skin conditions (non-pressure). Specifically, Resident #20 was observed with a bruise on the back of the left hand. Certified Nursing Assistant #10 was aware of the bruise on 3/4/2024; however, did not report the change in skin condition to Registered Nurse #3 until the Surveyor identified the bruise on the resident's left hand. The finding is: The facility's policy for Pressure Ulcer-Prevention and Care dated 2019 documented that during all care, all nursing staff are required to report any change in residents/patients' skin condition. In the event of skin integrity issues, a skin assessment will be conducted and interventions are placed to prevent pressure ulcers and to manage treatment. Resident #20 was admitted with diagnoses that included Diabetes Mellitus and Hypertension. The Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 15, which indicated the resident had intact cognition. The Minimum Data Set documented no behavioral symptoms. The resident had no pressure ulcers. During an initial tour on 3/4/2024 at 10:58 AM on the 2 North nursing unit, Resident #20 was observed sitting in a wheelchair in their room. A large bruise was observed on the dorsal (back) aspect of the resident's left hand. The resident stated while propelling their wheelchair into the room, the wheelchair was too close to the door frame and their hand hit against the door frame. A Physician's order dated 8/28/2023 and updated 2/19/2024 documented Eliquis (blood thinner) 2.5 milligrams; give 1 tablet by oral route every 12 hours. The Comprehensive Care Plan for Skin Integrity dated 11/28/2018 and last updated on 9/5/2023 documented the resident was at risk for impaired skin integrity. The interventions included to assess skin every shift. A Comprehensive Care Plan for Anticoagulant Therapy dated 11/29/2018 and updated on 2/7/2024 documented the resident was on anticoagulant therapy. Interventions included to administer anticoagulant therapy as per the Physician's order, assess for signs of abnormal bleeding, avoid bumping and handle the resident gently when providing hands-on care. The Skin Check/Care section of the Resident Certified Nursing Assistant (CNA) Documentation Record dated 3/2024 was reviewed and was signed for all shifts to indicate skin checks were completed. (continued on next page)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nursing progress note dated 3/7/2024 at 8:52 PM documented the resident was noted with a bruise to the dorsal aspect of the left hand. The resident was alert and oriented. As per the resident, they hit their hand on the door frame when leaving their room. The resident was able to self-propel their wheelchair. Licensed Practical Nurse #4, who was the medication nurse on duty on 3/4/2024 on the 7:00 AM - 3:00 PM shift, was interviewed on 3/7/2024 at 3:30 PM. Licensed Practical Nurse #4 stated they were not aware of the bruise on the resident's left hand. Licensed Practical Nurse #4 stated that they cared for the resident on 3/4/2024, 3/6/2024, and 3/7/2024; however, they did not notice the bruise. Licensed Practical Nurse #4 stated that it was not reported to them that the resident had a bruise on the left hand. Certified Nursing Assistant #9 was interviewed on 3/7/2024 at 3:15 PM and stated that they were assigned to Resident #20 on 3/7/2024 during the 7:00 AM-3:00 PM shift. Certified Nursing Assistant #9 stated they assisted the resident with morning care and also toileted the resident but did not observe the discoloration on the resident's left hand. Certified Nursing Assistant #10, who was assigned to Resident #20 on 3/4/2024, was interviewed on 3/8/2024 at 2:37 PM. Certified Nursing Assistant #10 stated that on 3/4/2024 they rendered care to Resident #20. Certified Nursing Assistant #10 stated they were responsible for checking the resident's skin while providing care. Certified Nursing Assistant #10 stated on 3/4/2024 they observed that the resident had a bruise on their left hand and the resident told them (Certified Nursing Assistant #10) that they banged their hand on the door frame. Certified Nursing Assistant #10 stated they did not report the bruise because they thought the nurse already knew about the bruise since the incident did not happen on their shift. Certified Nursing Assistant #10 stated they were going to report the bruise but forgot to do so. The Director of Nursing Services was interviewed on 3/8/2024 at 2:58 PM and stated that skin checks are supposed to be conducted by Certified Nursing Assistants during care. The Director of Nursing Services stated they expected the Certified Nursing Assistants to report any skin impairments to the nurse. The Director of Nursing Services stated that the Certified Nursing Assistant who identified the bruise on the resident's left hand should have reported the change in the resident skin to the nurse. 10 NYCRR 415.26(c)(1)(iv)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28670 Based on observation, record review and interviews during the Recertification Survey initiated on 3/4/2024 and completed on 3/9/2024, the facility did not ensure that the procedure that assure the accurate acquiring, receiving, dispensing and administration of all drugs and biologicals to meet the needs of each resident and the facility did not ensure that drug records are in order and that an account of all controlled drugs are maintained and periodically reconciled. This was identified for one (Resident #169) of eight residents reviewed for medication administration and for one (Unit 2 North) of four units reviewed for the Medication Storage task. Specifically, 1) Resident #169 had a Physician's order for Levothyroxine (Synthroid-thyroid medication) 50 microgram to be administered daily at 6:00 AM. During the medication pass observation on 3/6/2024 at 6:25 AM, the Levothyroxine 50 microgram was not available to be administered to the resident. Registered Nurse #4 borrowed the medication from another resident; 2) The Controlled Substance Administration Record was not reconciled for Resident #12 to reflect the accurate amount of Clonazepam 0.5 milligram that was observed in the blister pack. The findings are: 1) The facility Renewal of Medication and Reordering Policy dated 11/1/2023 documented Drugs and biologicals that are required to be refilled must be reordered from the issuing pharmacy not less than seven (7) days prior to the last dosage being administered to ensure that refills are readily available. Resident #169 was admitted with Hypothyroidism and Hypertension. A Minimum Data Set assessment dated [DATE] documented the resident's Brief Interview for Mental Status score was 14 which indicated the resident had intact cognition. A Physician's order dated 1/26/2024 and renewed on 2/23/2024 documented to administer Levothyroxine 50 micrograms one tablet via oral route once daily at 6:00 AM. A medication pass observation was conducted on 3/6/2024 at 6:25 AM for Resident #169. Registered Nurse #4 was unable to locate a Levothyroxine 50 microgram tablet for Resident #169 and was observed to remove a Levothyroxine 50 microgram tablet from another blister pack that had Resident # 49's identification label and then administered the Levothyroxine 50 microgram to Resident #169. Registered Nurse #4 was interviewed on 3/6/2024 at 6:30 AM and stated that they ran out of the Levothyroxine medication and needed to reorder the medication from the pharmacy for a refill for Resident #169. Registered Nurse #4 stated that they were not the regularly assigned nurse for Resident #169. Registered Nurse #4 stated that the medication should have been reordered when there were 3 to 4 pills left in the blister pack. Registered Nurse #4 stated when they run out of medication, they either borrow medication from another resident, from the blister pack of a resident who was discharged , or from another unit. Registered Nurse #4 stated they were aware they should not borrow the medications from one resident to administer to another resident. Registered Nurse #4 stated that they borrowed the Levothyroxine tablet because it was an important medication and that they did not want Resident #169 to miss their medication. (continued on next page)		

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 03/09/2024
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.			
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered Nurse #6, who was the Nursing Supervisor on the 11:00-7:00 AM shift, was interviewed on 3/6/2024 at 6:45 AM. Registered Nurse #6 stated if a nurse ran out of a critical medication like Eliquis (blood thinner), they were allowed to borrow the medication from another resident. Registered Nurse #6 stated Levothyroxine was not a critical medication and that the nurse should not have borrowed the medication to administer it to Resident #169. The Director of Nursing Services was interviewed on 3/6/2024 at 7:45 AM and stated that the nurses should absolutely not be borrowing medication from one resident to administer to another resident. The Director of Nursing Services stated that there should not be any occasion where the resident's medication should run out. The Director of Nursing Services stated that there is no policy for borrowing medications. 48827 2) Resident #12 was admitted with diagnoses that included Dementia, Anxiety, and Hypertension. The Quarterly Minimum Data Set assessment dated [DATE] documented the resident had a Brief Interview for Mental Status score of 14 which indicated the resident had intact cognition. The Minimum Data Set assessment documented the resident received anti-anxiety medication for seven days during the assessment look-back period. During a Medication Storage observation on 3/09/2024 at 10:04 AM on nursing unit 2 North, the medication cart was observed, including the Narcotic medications in the cart. Resident #12's Controlled Substance Administration Record for Clonazepam was reviewed. The Controlled Substance Administration Record documented that the last Clonazepam tablet was administered on 3/08/2024 at 8:00 AM. The amount of the Clonazepam medication remaining on the Controlled Substance Administration Record was documented to be 12 tablets; however, the Clonazepam medication blister pack contained only 11 tablets. The physician's order dated 2/23/2024 documented to administer Clonazepam 0.5 milligram tablet, give one tablet by oral route once daily in the morning at 8:00 AM for Anxiety disorder. The Medication Administration Record for March 2024 was reviewed and revealed the Clonazepam was signed as administered on 3/09/2024 at 8:00 AM. Licensed Practical Nurse #2 was interviewed on 3/09/2024 at 10:04 AM and stated they administered Clonazepam 0.5 milligrams at 8:00 AM for Resident #12 today (3/9/2024) but got called away and did not sign and update the Controlled Substance Administration Record. Licensed Practical Nurse #2 further stated they should have signed the Controlled Substance Administration Record at the time the tablet was removed from the blister pack. Registered Nurse Supervisor #2 was interviewed on 3/09/2024 at 11:23 AM and stated the nurses should sign the Controlled Substance Administration Record when they remove the tablet from the blister pack. The Director of Nursing Services was interviewed on 3/09/2024 at 12:30 PM and stated in order to reconcile narcotic medications they expected the nurses to sign off on the Controlled Substance Administration Record and Medication Administration Record when the narcotic medication is administered to a resident. (continued on next page)		

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10 NYCRR 415.18(b)(1)(2)(3)		

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41051 Based on observation, record review, and interviews during the Recertification Survey initiated on 3/4/2024 and completed on 3/9/2024 the facility did not provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition services. This was identified for one (Unit 1 North) of four Units observed during the initial tour. Specifically, Resident #107 and Resident #171 were observed eating their breakfast meal served on disposable plates, cups, and bowls. During the Resident Council Meeting held on 3/5/2024 eight of eight residents stated they often received disposable plates, cups, bowls, and utensils for meals on the weekend because of short staffing in the kitchen. The finding is: An undated facility policy titled Disposable Dinnerware documented the facility will use single-service items only in extenuating circumstances, such as dish-machine failure, individual resident needs, or other documented reasons. 1a) Resident #107 was admitted with diagnoses that included Alzheimer's Disease, Bipolar Disorder, and Chronic Obstructive Pulmonary Disease. Resident #107's Admission Minimum Data Set assessment dated [DATE] documented the resident's Brief Interview for Mental Status score was 3 which indicated the resident had severe cognitive impairment. During a tour of the 1 North Unit on 3/4/2024 at 9:01 AM Resident #107 was observed with a breakfast tray on their overbed table. A disposable plate and bowl were on Resident #107's meal tray. Resident #107 did not respond to questions. 1b) Resident #171 was admitted with diagnoses that included Multiple rib Fractures, Vascular Dementia, and Hypertension. Resident #171's Admission Minimum Data Set assessment dated [DATE] documented the resident's Brief Interview for Mental Status score was 7 which indicated the resident had severely impaired cognition. During a tour of the 1 North Unit on 3/4/2024 at 9:28 AM Resident #171 was observed with a breakfast tray on their overbed table. A disposable plate and bowl were on Resident #171's meal tray. Resident #171 stated they sometimes receive their meals on disposable dishes. Resident #171 stated they could not recall how often they received disposable products and they do not like to eat meals using disposable dishes. A Resident Council Meeting was conducted on 3/5/2024 from 10:19 AM to 11:30 AM. There were eight residents in attendance. All eight residents stated on the weekends they are often served meals on disposable plates. They stated they could not recall the specific dates they received their meals on disposable plates, but they did ask a staff person why they used the disposable items, and the staff person told them that the kitchen was short-staffed. The residents in attendance at the resident council meeting could not recall the name of the staff person. (continued on next page)		

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Food Service Director was interviewed on 3/9/2024 at 7:59 AM. The Food Service Director stated the facility policy is to use disposable dinnerware only if a resident is on isolation precautions or if there is a safety concern with a resident. The Food Service Director stated sometimes when they are extremely short-staffed on the weekends and when they do not have kitchen staff available to run the dishwasher, they use the disposable dinnerware. Dietary Aide #1 was interviewed on 3/9/2024 at 9:35 AM. Dietary Aide #1 stated they worked on 3/4/2024 and served the breakfast meal on the 1 North Unit. Dietary Aide #1 stated the kitchen was short-staffed on the morning of 3/4/2024 and they were the only dishwasher. Dietary Aide #1 stated their shift begins at 6:00 AM and breakfast is served between 7:10-7:15 AM. Dietary Aide #1 stated they chose to use the disposable dinnerware on the unit because they would not have time to wash all the dishes before lunchtime. The Food Service Director was re-interviewed on 3/9/2024 at 9:42 AM and stated they created the schedule for the kitchen and on 3/4/2024 they were fully staffed for breakfast; however, one of the scheduled dietary aides was not able to come in. The Food Service Director stated the overnight nursing supervisor received a call from the dietary aide at 5:00 AM and then the overnight nursing supervisor informed the cook. The Food Service Director stated the cook attempted to call a replacement staff member; however, was not successful. Cook #1 was interviewed on 3/9/2024 at 9:49 AM and stated they worked the morning of 3/4/2024. At 6:20 AM they were informed by the overnight nursing supervisor that one Dietary Aide would not be coming in for the 6:00 AM to 2:00 PM shift. Cook #1 stated they were not able to find another person to cover the shift. Cook #1 stated disposable dinnerware should only be used when a resident is on isolation or for resident safety. Cook #1 stated they will sometimes use disposable dinnerware for breakfast and lunch when they are short-staffed because a delay with the breakfast meal would cause the lunch meal to be late and a delay with the lunch meal would cause the dinner meal to be late. The Food Service Director was re-interviewed on 3/9/2024 at 10:43 AM and stated there are ongoing recruitment efforts, but dietary staff are hard to find. The Food Service Director stated they offered overtime as an incentive, monitored staff attendance, and if there was an attendance concern they provided education and discipline if needed. The Administrator was interviewed on 3/9/2024 at 3:34 PM and stated they were aware that disposable dinnerware is used from time to time. The Administrator was aware of staffing concerns in the kitchen and stated they offered overtime as an incentive for staff to come in. The Administrator stated they expect to have sufficient staff for the kitchen but while attempts were made to staff the kitchen the facility had to improvise and serve meals on disposable dinnerware. 10 NYCRR 415.14(b)(1)(2)		