STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335690	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Oaks Rehabilitation and Nursing Center	8565 Jericho Turnpike Woodbury, NY 11797

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review, and interviews during the recertification initiated on 09/02/2025 and completed on 09/08/2025, the facility did not ensure that food was stored, prepared, distributed, and served in accordance with professional standards for food service safety. This was identified during the Kitchen task observation on 09/02/2025 and during the Dining Task on 09/02/2025 at the lunch meal. Specifically, frozen food items (tiramisu, broccoli florets, pizza slices, a tray of diet pudding, regular pudding and peaches, roast beef, Brussel Sprouts) in the walk-in freezer were stored undated and or with opened packaging. Specifically, the facility did not monitor the temperature of cold food items (sandwiches, yogurt, milk) at the time of meal service. Upon request, temperatures were taken and found to be above the standard range (cold food temperatures should be 40 degrees Fahrenheit or below) for food service safety (United States Department of Agriculture). The finding is:A facility policy and procedure titled Food Storage, dated 08/2024, documented all perishable foods will be stored at proper temperatures, refrigerated at 35 degrees to 41 degrees Fahrenheit, and frozen at zero (0) to minus ten (10) degrees Fahrenheit. All food will be dated upon stocking when removed from its original packaging. If not in the original packaging, all food items must be dated and labeled with the name of the contained food.A facility policy and procedure titled Meal Temperature, dated 08/2024, documented to ensure the safety and quality of the food items. It is the policy to obtain and record the temperature of food items prior to serving to residents. The Kitchen observation was conducted with the Clinical Dietitian on 09/09/2025 at 9:46 AM. A walk-in freezer unit was observed with an open clear bag of an unidentified and undated food item (The Registered Dietitian was unable to identify the food item); 1 individual container of tiramisu (as identified by the Registered Dietitian) unlabeled and undated; an open package of broccoli florets wrapped in plastic wrap unlabeled and undated; 1 bag of Brussel sprouts out of its original packaging, undated; individual slices of pizza in plastic wrap undated; an unopened package of slices of pizza undated; three (3) packages of roast beef out of its original packaging, undated; one (1) tray each of diet pudding, regular pudding and peaches undated; and package unlabeled and undated (the Registered Dietitian was unable to identify the food item.)During an interview on 09/02/2025 at 9:52 AM, Dietary Aide #1 stated that they perform the job of a storeroom person (put away deliveries); however, the Cooks are responsible for putting food away properly once they are done using the item. During an interview on 09/03/2025 at 1:33 PM, the Food Service Director stated that everything must be labeled and dated, including if something is taken out of its original packaging, it must have the item name and date of delivery, and an open package also needs to have a label and date on the wrapping. This is to maintain the quality of the food item. Dining observation was conducted during the lunch service on Unit Two (2) South on 09/02/2025 at 12:00 PM. Dietary Aide #2 was observed placing cold food items (milk, juice, yogurt, dessert, sandwiches) on the individual resident trays. These cold food items were observed in a container with ice, except for the sandwiches, which were on a tray without ice or other cooling mechanism. On 09/02/2025 at 12:20 PM, Dietary Aide #3 was observed taking the temperature of the hot food items. Dietary Aide #2 and Dietary Aide #3 were not observed taking the cold food temperatures. Dietary Aide #3 was immediately interviewed and stated that they do not take the (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	temperature of the cold food items except when it is the main entree. They further stated that the cold food is delivered on ice; therefore, it is at the appropriate temperature. The lunch meal service began on 09/02/2025 at 12:27 PM. Dietary Aide #2 was immediately interviewed and stated they started to set up the trays with the cold food items (milk, yogurt, etc.) at approximately 12:15 PM. Dietary Aide #2 stated that they prepare all the trays prior to the start of meal service. They further stated that they do not take the temperature of the cold food items as they are on ice. Dietary Aide #3, at the request of the State Agency, took the temperature of the cold food items on 09/02/2025 at 12:30 PM, with the findings of 60 degrees Fahrenheit for a tuna sandwich, 59 degrees Fahrenheit for a cheese sandwich, 42.1 degrees Fahrenheit for a four (4) ounce container of milk and at 12:50 PM, 50.2 degrees Fahrenheit for a yogurt container. During an interview on 09/03/2025 at 1:33 PM, the Food Service Director stated approximately one-half hour prior to lunch service, the cold food items, such as desserts, milk, and sandwiches, are transported in a container with ice to the unit for the Dietary Aides to place on the individual resident meal trays. Resident Unit 2-South lunch meal service time is 12:30 PM, so the items go up at 12:00 PM. The Food Service Director stated that a second Dietary Aide will bring the hot food to the unit and is responsible for obtaining and recording the food temperatures. They further stated that cold food items are not checked for temperature on the units because they are always refrigerated and iced. During an interview on 09/04/2025 at 9:56 AM, the Administrator stated that they would expect items in the kitchen to be properly wrapped, labeled, and dated. The Administrator stated that they were aware that food temperatures are to be monitored; however, they were not aware that the cold food temperatures were not being monitored. 10 NYCRR 415.14(h)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review during the Recertification Survey initiated on 09/02/2025 and completed on 09/08/2025, the facility did not ensure each resident had the right to be treated with respect and dignity, including the right to be free from any physical restraints imposed for the purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This was identified for one (1) (Resident #36) of one (1) resident reviewed for Physical Restraints. Specifically, on 09/02/2025, Resident #36 was observed sleeping in a bed with the bed positioned between another empty bed on the right side and a Geri chair on the left side, thereby blocking the resident from getting out of the bed. During an interview on 09/05/2025, the resident's assigned Certified Nursing Assistant #5 acknowledged they intentionally placed the resident's bed between another bed and the Geri chair to prevent the resident from getting out of bed.The finding is:The facility policy titled Policy and Procedure for Restraint Use last reviewed on 09/2022, documented the facility was to maintain and establish a restraint-free environment for all residents. It may be necessary to use some measures of restraint to protect a resident from self-injury or from inflicting injury upon another resident. Restraints will only be applied when all other interventions have proven to be unsuccessful. The residents shall have the expectation that while residing at the facility, their right to freedom and dignity as individuals shall be acknowledged and promoted. The facility will provide the least restrictive environment appropriate to the resident's individual needs. This philosophy is expressed to the residents and their family members.Resident #36 was admitted with diagnoses including Muscle Wasting and Atrophy, Repeated Falls, and Generalized Anxiety Disorder. The Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status Score of 99, indicating the resident had severe cognitive impairment. The Minimum Data Set documented the resident required partial or moderate assistance when rolling left and right in bed, sitting to lying in bed, lying to sitting on the side of the bed, and during transfers. The resident did not have physical restraints or alarms during the assessment period. The resident did not have any falls during the assessment period.A Comprehensive Care Plan titled Falls/Safety last revised 08/10/2025 documented interventions including placing floor mats on each side of the resident's bed, keeping the bed in the lowest position, and referring to rehabilitation services for evaluation as needed.A nurse's progress note dated 09/01/2025 documented that Resident #36 was found on their knees on the floor mat by the bed with the resident's body and head in bed. The bed was in the lowest position. There was no injury noted.A Physical Therapy Interim note dated 09/02/2025 documented that the resident was screened by Physical Therapy after having fallen out of bed on 09/01/2025. There were no changes to the resident's range of motion. The resident's functional mobility remained the same. The resident had floormats in place. Physical Therapy services will continue to monitor the resident.During an observation on 09/02/2025 at 11:10 AM, Resident #36 was observed resting in their bed. The bed was in the lowest position. An empty bed was observed along the right side of the resident's bed, and a Geri-chair was placed on the floor mat along the left side of the resident's bed, thereby blocking both sides of the resident's bed. During an observation and interview on 09/05/2025 at 08:35 AM, the resident was observed in their room sitting in a Geri-chair. Certified Nursing Assistant #5 was also present in the room. A floor mat was observed on each side of the resident's bed. Certified Nursing Assistant #5 stated they were assigned to Resident #36 on 09/02/2025. They put the empty bed and the Geri-chair alongside the resident's bed to stop the resident from getting out of bed. Certified Nursing Assistant #5 stated the resident already had a fall on 09/01/2025, and they wanted to prevent the resident from getting out of bed and falling again.During an interview on 09/05/2025 at 10:09 AM, Registered Nurse #4, the Charge Nurse, stated they did not know that Certified Nursing Assistant #5 positioned the resident's bed between an empty and a Geri-chair to (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stop the resident from getting out of bed. Certified Nursing Assistant #5 should have kept the floor mats on both sides of the bed while the bed was at the lowest position. Registered Nurse #4 stated the resident had a history of falls, and last fell on [DATE].During an interview on 09/05/2025 at 12:45 PM, Physical Therapist #1 stated they were familiar with Resident #36 and the resident had a history of Dementia and falls. The resident required one person's assistance for bed mobility and transfers. Physical Therapist #1 stated that floor mats were in place when the resident was in bed as an intervention for fall prevention. Physical Therapist #1 stated the resident had a fall from bed on 09/01/2025, and they recommended having the bed in the lowest position with a floor mat on both sides of the bed. Physical Therapist #1 stated that nursing staff should implement the recommended interventions and should not position the resident's bed in a manner that would restrict the resident's movement.During an interview on 09/08/2025 at 10:05 AM, the Director of Nursing Services stated the facility was a restraint-free facility. The Director of Nursing Services stated Certified Nursing Assistant #5 should have utilized the floor mats on both sides of the bed and should not have placed an empty bed on one side of the resident's bed and a Geri-chair on the other side of the resident's bed, as this would be a restriction to the resident's movements while in bed.10 NYCRR 415.4(a)(2-7)

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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. Based on observation, record review, and interviews during the Recertification Survey initiated on 09/02/2025 and completed on 09/08/2025, the facility did not ensure that each resident received adequate supervision and assistance devices to prevent accidents. This was identified for one (Resident #12) of five residents reviewed for Accidents. Specifically, Resident #12 was at risk for elopement and had a physician's order for a Wanderguard (a wearable bracelet for residents at risk for wandering, which causes an alarm when the resident approaches a restricted area). On 08/01/2025, the resident removed the Wanderguard; however, no new interventions were put in place to ensure the resident was appropriately supervised and did not remove the Wanderguard. During an observation on 09/05/2025, Resident #12 was not wearing their Wanderguard, and the assigned staff were not aware that the resident did not have their Wanderguard in place.The finding is:The facility policy titled Code Alert System/Code Alert Bracelet, last reviewed 01/2022, documented Code Alert System is designed to trigger when a resident passes the area where parameters have been set. The system is triggered by a bracelet transmitter placed on or in the vicinity of the resident in question. Once the decision has been made that the resident exhibits unsafe wandering or is at risk for elopement, the bracelet transmitter is placed on the arm, leg, wheelchair, walker, or pocketbook of those residents who wander or are at risk. The nursing supervisor will monitor that the nursing staff check the location of the bracelet on the resident, assistive device, or wheelchair every day.Resident #12 was admitted with diagnoses including Multiple Sclerosis, Malnutrition, and Chronic Pain. The 07/03/2025 Quarterly Minimum Data Set assessment documented a Brief Interview of Mental Status score of 3, indicating the resident had severe cognitive impairment; the resident required supervision or touching assistance for ambulation and transfers; and no wandering behaviors were exhibited.A Nursing-Elopement Risk Evaluation dated 04/01/2025 documented the resident was at risk for elopement.A Comprehensive Care Plan, titled Elopement/Wandering, effective 04/02/2025, last updated on 08/01/2025, documented resident exhibited wandering behavior. Interventions included ensuring proper placement of the ankle alert and checking for any malfunction. The Code alert (Wanderguard) was applied to the right ankle. The Comprehensive Care Plan update on 05/27/2025 documented the resident was noticed with wandering behaviors, such as leaving the unit and walking toward the front door unattended. The resident was redirected, and an order was obtained for Code alert and applied. The Comprehensive Care Plan update on 08/01/2025 documented the resident removed the Wanderguard from the right lower extremity by cutting the strap; the room was searched, and no sharp objects were found to have cut the strap. The strap was replaced, and the Wanderguard was reapplied to the right lower extremity. Will continue to monitor. There were no new interventions added to the care plan.A physician's order dated 05/16/2025 documented Wanderguard to the right lower extremity each shift.A review of August/September 2025 Treatment Administration Records revealed Resident #12's Wanderguard was present on the right lower extremity each shift as evidenced by the nurses' signature.During an observation and interview on 09/05/2025 at 10:55 AM, Resident #12 was sitting in the day room. The surveyor observed the resident ambulate independently with a cane from their room to the day room. The surveyor asked Resident #12 to show the Wanderguard bracelet on the resident's right lower extremity. The resident did not understand the question.During an observation and interview on 09/05/2025 at 11:00 AM, the surveyor requested Certified Nursing Assistant #4, who was in the day room, to check Resident #12's lower extremities for a Wandergurad bracelet. Certified Nursing Assistant #4 stated Resident #12 was not assigned to them. Certified Nursing Assistant #4 checked the resident's lower extremities and stated the resident did not have a Wanderguard on. During an interview on 09/05/2025 at 11:10 AM, Registered Nurse Charge Nurse #1 stated they found the Wanderguard on the resident's bedside table without the strap. Registered Nurse Charge Nurse #1 stated they have to get a new strap and reapply the Wanderguard (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to the resident's right lower extremity.During an interview on 09/05/2025 at 1:20 PM, Licensed Practical Nurse #2 (the medication nurse) stated they provided medications to Resident #12 this morning and did not check if the resident was wearing the Wanderguard. The Wanderguard placement was supposed to be checked each shift, and they (Licensed Practical Nurse #2) have not yet completed that task. Licensed Practical Nurse #2 stated, I guess I could have checked the at the same time that I administered the medications. Licensed Practical Nurse #2 could not recall seeing the Wandergurad on the resident's bedside table when they administered the medications. During an interview on 09/05/2025 at 2:15 PM, Licensed Practical Nurse Risk Manager #1 stated that after the resident removed the Wanderguard on 08/01/2025, the care plan should have definitely been updated with new interventions, like increased monitoring or placing the Wanderguard bracelet in a different location, and another elopement risk assessment should have been completed.During an interview on 09/05/2025 at 3:01 PM, Registered Nurse Charge Nurse #1 stated the resident had previously removed the Wanderguard on 08/01/2025, and since it was the first time the resident removed the Wanderguard, 30-minute monitoring was not necessary. We just had to reapply the Wanderguard.A progress note, written by Registered Nurse Charge Nurse #1, dated 09/05/2025 at 4:16 PM, documented resident's Code alert (Wanderguard) was noted to be missing today. Supervisor was notified. A function check was completed on the Code alert device by the Assistant Director of Nursing, and the device was found to be working properly. The Code alert was reapplied and placed on the resident's right lower extremity. The resident was noncompliant with keeping the Code alert on the right lower extremity, and as a result, the resident has been placed on 30-minute safety checks. The care plan has been updated accordingly. The resident was also educated on the importance of keeping the Code alert on.During an interview on 09/08/2025 at 8:56 AM, the Director of Nursing Services stated appropriate actions were taken on 08/01/2025 when the resident removed the Wanderguard. The device was placed back on the resident's right lower extremity. 30-minute monitoring was added as a new intervention after the Wanderguard was found to be missing on 09/05/2025. The Director of Nursing Services could not state if an elopement risk assessment should have been completed on 08/01/2025 or if increased monitoring should have been added as an intervention.10 NYCRR 415.12(h)(2)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, record review, and interviews during the Recertification Survey, initiated on 9/2/2025 and completed on 9/8/2025, the facility did not ensure that each resident who required respiratory care was provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. This was identified for one (1) (Resident #129) of three (3) residents reviewed for Respiratory Care. Specifically, Resident #129 did not receive pulse oximetry (oxygen saturation) monitoring (measures the oxygen saturation in blood) as recommended by the Physician in a progress note dated 09/01/2025; however, the Physician did not write an order for their recommendation. The finding is:Resident #129 was admitted to the facility with diagnoses including Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, and Schizophrenia. The 08/11/2025 quarterly Minimum Data Set assessment documented a Brief Interview for Mental Status score of 12, indicating the resident had moderate cognitive impairment; received oxygen therapy while a resident; and received non-invasive mechanical ventilator (BiPAP-Bilevel Positive Airway Pressure, a non-invasive ventilation technique that uses a machine to deliver pressurized air to the lungs during sleep) while a resident.Resident #129 had the following current physician orders as of 09/02/2025: -Oxygen at 3 liters per minute continuously for Chronic Obstructive Pulmonary Disease. -Head of bed elevated to avoid shortness of breath while lying flat for Chronic Obstructive Pulmonary Disease.-Ipratropium 0.5 milligram-albuterol 3 milligram/3 milliliter nebulization solution, inhale every 6 hours for Chronic Obstructive Pulmonary Disease.-Advair Diskus 250 microgram-50 microgram dose powder for inhalation, 1 puff every 12 hours for Chronic Obstructive Pulmonary Disease.-Nurse to ensure the heart monitor is on and working at all times for atherosclerotic heart disease.-BiPAP (noninvasive ventilation that helps you breathe) at the hour of sleep for sleep apnea (a sleep disorder characterized by repeated episodes of pauses in breathing during sleep).A physician's order dated 06/20/2025 documented Vital Signs every shift for seven days, then every day-monitor blood pressure, oxygen saturation, pulse, respirations, temperature. This order was discontinued on 09/01/2025.A Physician #1 progress note dated 09/01/2025 documented follow-up for Chronic Obstructive Pulmonary Disease, vital signs stable, decreased breath sounds bilaterally (noises made when breathing and assessed with stethoscope), slight rales at bases of lungs (abnormal lung sounds that resemble rattling caused by fluid in the lungs or airways), maintain oxygen saturation above 88%; BiPap nightly and as needed for hypoxia (inadequate oxygen supply to body tissues).A review of the resident's oxygen saturation monitoring screen in the electronic medical record revealed that the nursing staff stopped monitoring the resident's oxygen saturation levels on 09/01/2025. There was no associated progress note with an explanation. The oxygen saturation monitoring was done every day since the resident was admitted in February 2025 until 09/01/2025.During an observation and interview on 09/02/2025 at 11:15 AM, Resident #129 was in bed. The oxygen cannula had been removed by the resident. The resident stated they did not need the oxygen at present and had their oxygen cannula. During an interview on 09/05/2025 at 11:15 AM, Registered Nurse Charge Nurse #1 stated the resident's oxygen saturation levels had been stable, so the doctor said the oxygen saturation (pulse oximetry) levels did not have to be checked any further, and that is why oxygen saturation has not been monitored since 09/01/2025.During an interview on 09/05/2025 at 11:55 AM, Physician #1 stated they did not order or give directions to stop monitoring oxygen saturation. Physician #1 stated the resident was on oxygen and required their oxygen saturation to be monitored daily.A progress note written by Registered Nurse Charge Nurse #1, dated 09/05/2025 at 12:52 PM, documented that oxygen saturation monitoring is no longer required at this time, as the resident maintains oxygen saturation levels stable with supplemental oxygen in place and shows no signs of respiratory distress. General monitoring of the resident's respiratory status will continue.During a re-interview on 09/05/2025 at 1:00 PM, Physician #1 stated they did not give direction to discontinue monitoring Resident #129's oxygen (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	saturation, which should be checked daily to make sure the resident was not desaturating (decreasing level of oxygen in the blood); in which case, a pulmonary follow-up may be needed. Physician #1 stated they do not write an order for monitoring oxygen saturation--nursing should be checking oxygen saturation as general practice for a resident on oxygen therapy.A nursing progress note dated 09/06/2025 at 2:11 PM, written by Registered Nurse Charge Nurse #1, documented resident was seen today by the Physician (Physician #1). A new order was received to monitor oxygen saturation daily. A physician's order dated 09/06/2025 documented Pulse Oximetry every day on the 7:00 AM-3:00 PM shift.During an interview on 09/08/2025 at 9:00 AM, the Director of Nursing Services stated the order for vital signs included monitoring for oxygen saturation, and the Physician may not have realized that when the order to discontinue monitoring vital signs was given on 09/01/2025. The Director of Nursing Services stated the nurses do not read the doctor's progress notes. If the Physician wanted nurses to maintain oxygen saturation above 88%, they should have written an order. The conversation between the doctor and the nurse (Licensed Practical Nurse #3) on 09/01/2025, regarding the need for oxygen saturation monitoring, was not documented, and there may have been miscommunication. During an interview on 09/08/2025 at 9:40 AM, Licensed Practical Nurse #3 stated they had a conversation with Physician #1 on 09/01/2025; the Physician stated the vital signs were stable and that the vital sign order could discontinued; the vital sign order included oxygen saturation and the doctor did not say to continue oxygen saturation monitoring; Licensed Practical Nurse #3 stated they do not read the doctor's progress notes; the doctor may not have realized that the oxygen saturation monitoring was part of the vital sign order and therefore the oxygen saturation monitoring was being discontinued also. During an interview on 09/08/2025 at 11:00 AM, the Medical Director #1 stated Physician #1 should have written for monitoring the resident's oxygen saturation to ensure the oxygen saturation remained above 88%. 10 NYCRR 415.12(k)(6)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews during the Recertification Survey initiated on 09/02/2025 and completed on 09/08/2025 the facility did not ensure that it maintained an infection prevention and control program designed to help prevent the development and transmission of communicable disease and infections for 1) one (Resident #16) of one resident reviewed for Pressure Ulcers and for one (1) (Resident #111) of three (3) residents reviewed for Transmission-Based Precautions. Specifically, 1) during the wound care observation for Resident #16 (bilateral heel wounds) on 09/04/2025, Licensed Practical Nurse #1 did not perform hand hygiene during the various steps of the wound care treatment process, allowed the cleansed heel wounds to come in contact with a dirty surface, and did not re-cleanse the heel wounds. 2) Resident # 111 was placed on Contact Isolation for Klebsiella Pneumoniae (a bacterial infection often spread through person-to-person contact or contaminated surfaces and equipment) in the wound as per the physician's order. Certified Nursing Assistant #2 was observed entering Resident #111's room without wearing appropriate Personal Protective Equipment (PPE), including a gown and gloves, to deliver Resident #111's lunch tray. Certified Nursing Assistant #2 did not perform hand hygiene before entering or exiting from Resident #111's room. The findings are: The facility policy titled Wound Care, effective 10/16/2024, documented: arrange the wound care supplies so they can easily be reached; wash and dry hands thoroughly; place on gloves; a disposable cloth may be placed under the wound to serve as a barrier to protect the bed linen and other body sites; remove old dressing and discard in receptacle and wash hands thoroughly; put on clean gloves and clean the wound bed with normal saline; discard gloves and wash hands thoroughly; put on clean gloves and apply the wound medication to the wound; cover the wound with a dressings and wash and dry hands thoroughly. The facility's policy titled Contact Isolation last revised on 08/2024, documented that Contact Isolation/precautions are intended to prevent the transmission of infectious agents, which are spread by direct or indirect contact with the resident or the resident's environment. Direct contact transmission involves direct body-to-body contact and the transfer of microorganisms from a susceptible host to an infected or colonized resident, such as when staff perform resident care activities that require direct personal contact. Indirect contact transmission involves contact of a susceptible host with a contaminated intermediate object, usually inanimate, such as contaminated instruments or dressings, or contaminated gloves that are not changed between residents. Fundamentals of Contact Isolation includes hand hygiene, the single most important measure for preventing the spread of infection; and Personal Protective Equipment (PPE), including masks, gowns, and gloves, is worn alone or in combination to provide barrier protection. 1) Resident #16 was admitted with diagnoses including Cerebrovascular Accident, Non-Alzheimer's Dementia, and Pressure Injuries to the Right and Left Heels. The 08/08/2025 admission Minimum Data Set assessment documented a Brief Interview for Mental Status score of four (4), indicating the resident had severe cognitive impairment, and had one Stage three (3) pressure ulcer (full-thickness skin loss where fat is visible in the wound bed) and one unstageable pressure ulcer (a full-thickness skin and tissue loss that is fully or partially covered by slough-dead tissue). A Comprehensive Care Plan titled, Pressure Ulcer-Right Heel Stage three (3), effective 08/06/2025, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented an update on 09/04/2025 by Wound Care Registered Nurse #1 indicating the wound consultant and wound nurse saw the resident this week for weekly rounds, right heel Stage 3, 2.6 centimeters x 2.6 centimeters x 0.2 centimeters, 80% granulation tissue (healing tissue), 20% slough/fibrin tissue (dead tissue/protein that forms a clot), 30 % dermal tissue (skin), small amount serous drainage (clear fluid). A Comprehensive Care Plan titled, Pressure Ulcer-Left Heel, effective 08/06/2025, documented an update on 09/04/2025 by Wound Care Registered Nurse #1, indicating the wound consultant and wound nurse saw the resident this week for left heel deep tissue pressure injury 4.4 centimeters x 3.4 centimeters x 0 centimeters, 100% epithelial tissue (protective barrier to wound). A Physician's order dated 08/07/2025 documented cleanse the right heel with normal saline, apply Hydrogel (wound treatment), and apply a clean dry dressing every day; cleanse the left heel with normal saline, apply skin prep, and cover with an Allevyn (foam) dressing every day. During an observation on 09/04/2025 at 10:20 AM, Licensed Practical Nurse #1 performed Resident #16's wound treatment for both heels. The nurse worked alone without assistance from other staff. The resident was in bed with their heels resting on a pillow. The nurse wore a gown because the resident was on Enhanced Barrier Precautions. The nurse set up all the wound care supplies on a clean field on the overbed table. The nurse washed their hands prior to beginning the wound care treatment and then put on multiple pairs of gloves. The nurse performed the wound care treatment on the left heel first; they removed the old dressing, removed one pair of gloves, cleansed the heel wound with normal saline, then allowed the cleansed heel to come in contact with the dirty pillow (there was no protective barrier), applied the wound treatment and applied a dressing; and removed another pair of gloves. The nurse then proceeded to do the wound care on the right heel without performing hand hygiene; they removed the old dressing, removed one pair of gloves, cleansed the heel wound with normal saline, and allowed the cleansed heel to come in contact with the dirty pillow. There was no protective barrier placed on the pillow. The nurse applied the wound treatment and dressing and then removed another pair of gloves. During an interview on 09/04/2025 at 10:20 AM, Licensed Practical Nurse #1 stated they were supposed to get assistance to elevate the resident's heels from another staff member, but both the Charge Nurse and the Certified Nursing Assistant were busy. Licensed Practical Nurse #1 stated they should have recleaned the wounds and applied a clean barrier. Licensed Practical Nurse #1 stated they normally used the hand sanitizer during wound care to sanitize their hands during the various wound treatment steps, but they forgot. During an interview on 09/04/2025 at 12:20 PM, Registered Nurse Wound Care Nurse #1 stated that Licensed Practical Nurse #1 should have waited for someone to help elevate the resident's legs. Registered Nurse Wound Care Nurse #1 also stated that the nurse was not supposed to use multiple gloves. They should have used one pair of gloves for each step of the dressing change and sanitized their hands. During an interview on 09/05/2025 at 9:37 AM, Licensed Practical Nurse Infection Preventionist #1 stated that hand hygiene must be performed during wound care rather than using multiple gloves. The nurse should have re-cleansed the wound areas after the resident's heels came in contact with the dirty surface. During an interview on 09/05/2025 at 10:28 AM, the Director of Nursing Services stated Licensed (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Practical Nurse #1 should have performed hand hygiene during the wound care rather than wearing multiple gloves and then removing each pair at a time when hand hygiene should have been performed. The Director of Nursing Services stated that Licensed Practical Nurse #1 should have had someone help elevate the resident's legs or used a clean field to rest the cleansed heels. 2) Resident #111 was admitted with diagnoses of malignant Neoplasm (Cancer) of the Bone, Dementia, and Klebsiella. The admission Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of nine (9), which indicated Resident #111 had moderate cognitive impairment. The admission Minimum Data Set (MDS) assessment documented that Resident #111 had an Active diagnosis, including a Multi-Drug-Resistant Organism (bacteria that have developed resistance to multiple classes of antimicrobial drugs, making infections difficult or impossible to treat with standard antibiotics) and Wound Infection. A Comprehensive Care Plan (CCP) titled, Contact Isolation Precaution: Right Hip Wound Klebsiella Pneumoniae dated 08/23/2025, documented interventions including maintaining strict infection control protocols in handling the contact isolation waste, monitoring signs and symptoms of the causative organisms, reporting to the Physician for any changes, and applying isolation equipment upon entry to the room. A Physician's Order dated 08/23/2025 documented Augmentin (an antibiotic) 875 milligrams-125 milligrams tablet every twelve (12) hours for five (5) days for changes in skin texture. A Physician's Order dated 08/25/2025 documented Contact Isolation every shift. During an observation on 09/02/2025 at 10:24 AM, Resident #111 was wheeled by their family member from Rehabilitation therapy. A precaution sign was posted outside Resident #111's room indicating Contact Isolation Precautions: everyone must clean their hands before entering and when leaving Resident #111's room. The sign also instructed to use Personal Protective Equipment (PPE), including wearing a gown and gloves before entering Resident #111's room and discarding the gown and gloves before exiting the room. The Personal Protective Equipment (PPE) was stored inside the resident's room. Resident #111's room. The family member was not wearing any Personal Protective Equipment. During an observation on 09/02/2025 at 12:20 PM, Certified Nursing Assistant #2 was observed entering Resident #111's room with a lunch tray without using a gown and gloves. Certified Nursing Assistant #2 did not perform hand hygiene before entering Resident #111's room and when exiting the room. During an interview on 09/02/2025 at 12:38 PM, Certified Nursing Assistant #2 stated that they read the sign outside Resident #111's room and knew that they were supposed to wear Personal Protective Equipment prior to entering the room. Certified Nursing Assistant #2 stated they did not perform hand hygiene and did not put on a gown and gloves because there were none outside Resident #111's room. Certified Nursing Assistant #2 stated the Personal Protective Equipment (PPE) was inside the room by the wall near the door. Certified Nursing Assistant #2 stated they did not use any of the gloves or gown because they were just handing the tray to Resident #111's family member. Certified Nursing Assistant #2 stated they should have used a hand sanitizer before entering the room and when exiting Resident #111's room, but they forgot. During an interview on 09/04/2025 at 10:17 AM, Registered Nurse #1, Unit Manager, stated the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Personal Protective Equipment (PPE) and hand sanitizer were available inside Resident #111's room. Registered Nurse #1 stated that Resident #111 had completed their antibiotics, and the bacteria were in Resident #111's wound on the right hip. Registered Nurse #1 stated that Resident #111's wound was covered. The possibility of contact with the bacteria when Certified Nursing Assistant #2 handed the tray was minimal. Registered Nurse #1 stated that they do the full donning of gown and gloves during high contact care, including wound care, toileting, and personal hygiene care. Registered Nurse #1 stated that Certified Nursing Assistant #2 should have performed hand hygiene before entering Resident #111's room and when exiting the room. During an interview on 09/05/2025 at 9:37 AM, the Infection Preventionist stated that they expect the staff to follow the facility's policy for infection control. The sign outside the resident's door only applied if the staff was performing high-contact care, not for delivering trays or giving medication. The Infection Preventionist stated that high contact care includes providing care during wound care, toileting, and personal hygiene care. The Infection Preventionist stated that the Certified Nursing Assistant #2 should have performed hand hygiene before entering the room and when exiting the room as instructed on the sign outside the door. The Infection Preventionist stated that the Personal Protective Equipment (PPE) was inside the room by the door, as they expect staff to wear proper Personal Protective Equipment once inside the room. During an interview on 09/05/2025 at 10:28 AM, the Director of Nursing Services stated that when a resident is on Contact Isolation, it is the resident who has an infection that is on contact isolation and not the environment. The Director of Nursing Services stated that they expected the staff to perform hand hygiene before entering and exiting the resident's room. The Director of Nursing Services stated that Personal Protective Equipment (PPE) is available inside the resident's room for the staff to use. The Director of Nursing Services stated they expect the staff to wear the Personal Protective Equipment during high-contact care for Resident #111. 10 NYCRR 415.19(a) (1-3)(b) (4)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observations, interviews, and record review during the Recertification Survey initiated on 09/02/2025 and completed on 09/08/2025, the facility did not ensure nursing staffing was posted daily and included the actual number of licensed and unlicensed staff working hours per shift. Specifically, the facility's entrance lobby was observed on 09/02/2025 at 09:28 AM with the nursing staffing sheet posted for 08/29/2025. Additionally, the nursing staffing sheets dated 09/02/2025 to 09/03/2025 did not include the actual hours worked by the licensed and unlicensed nursing staff per shift.The finding is:The facility's policy titled Staffing, last revised 11/01/2023, documented the facility will provide sufficient numbers of licensed and non-licensed personnel (Registered Nurse, Licensed Practical Nurse, and Certified Nursing Assistant) on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans. The policy did not include guidance related to nursing staffing posting.The facility did not provide a policy related to the staffing posting requirement. During an observation on 09/02/2025 at 9:28 AM, a nursing staffing sheet was posted at the facility entrance by the receptionist area. The nursing staffing sheet was dated 08/29/2025 and did not include the actual hours worked for licensed and unlicensed nursing staff for each shift (7:00 AM-3:00 PM; 3:00 PM-11:00 PM; 11:00 PM-7:00 AM).During an observation on 09/02/2025 at 3:15 PM, a nursing staffing sheet was posted at the facility entrance by the receptionist area. The nursing staffing sheet was dated 09/02/2025 and included projected nursing staffing for the night (11:00 PM-7:00 AM) shift. The nursing staffing sheet did not include the actual hours worked by the licensed and unlicensed nursing staff for each shift (7:00 AM-3:00 PM; 3:00 PM-11:00 PM; 11:00 PM-7:00 AM).During an observation on 09/03/2025 at 9:00 AM, a nursing staffing sheet was posted at the facility entrance by the receptionist area. The nursing staffing sheet was dated 09/03/2025 and included projected nursing staffing for the evening (3:00 PM-11:00 PM) and night (11:00 PM-7:00 AM) shift. The nursing staffing sheet did not contain the actual hours worked by the licensed and unlicensed nursing staff for each shift (7:00 AM-3:00 PM; 3:00 PM-11:00 PM; 11:00 PM-7:00 AM).During an interview on 09/03/2025 at 10:29 AM, the Staffing Coordinator stated they were responsible for completing the nursing staffing sheet. The Staffing Coordinator stated they prepared the nursing staffing sheet the day prior, during weekdays, and on Fridays for the weekends. The Staffing Coordinator stated they used the projected nursing schedule and the actual resident census at the time they prepared the nursing staffing sheet. The Staffing Coordinator stated the nursing staffing sheet is sent to the receptionist, who is responsible for posting the nursing staffing sheet in the morning. The Staff Coordinator stated that the information on the nursing staffing sheet may not reflect actual nursing staffing, and they do not revise the sheet for any changes in nursing staffing numbers or resident census. The Staffing Coordinator stated there was no one assigned to revise the nursing staffing sheet posted in the receptionist area. The Staffing Coordinator further stated they were not aware that the facility's nursing staffing sheet must include actual hours worked by licensed and unlicensed nursing staff each shift.During an interview on 09/03/2025 at 11:20 AM, the Director of Nursing Services stated the receptionist is responsible for posting the nursing staffing sheet daily, and the nursing supervisor on shift is responsible for revising information on the sheet as necessary to reflect actual nursing staffing and resident census. The Director of Nursing Services stated that they were not aware that the facility's nursing staffing sheet must include actual licensed and unlicensed nursing staff working hours for each shift.During an interview on 09/03/2025 at 1:22 PM, the Administrator stated the nursing staffing sheet must be posted daily, and the Registered Nurse supervisor on shift is responsible for revising and updating the information on the sheet as necessary to reflect actual nursing staffing and resident census. The Administrator stated that they were not aware that the facility's nursing staffing sheet must include actual licensed and unlicensed nursing staff working hours for each shift.During an interview on 09/04/2025 at 8:25 AM, Receptionist #1 stated they were responsible for posting the nursing staffing sheet daily; however, they do not make (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	changes to the nursing staffing sheet. Receptionist #1 stated they had posted the nursing staffing sheet on Monday (09/01/2025). Receptionist #1 stated they were not sure why Friday's (08/29/2025) staffing sheet was still displayed on Tuesday (09/02/2025). Receptionist #1 stated they should have checked and ensured the daily nursing staffing sheet was posted.10 NYCRR 415.13

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F 0838 Level of Harm - Potential for minimal harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews during the Recertification Survey initiated on 09/02/2025 and completed on 09/08/2025, the facility did not ensure the Facility Assessment determined and indicated specific nursing staffing necessary to care for residents during both day-to-day operation (including night and weekends) and emergencies. This was identified during the Sufficient Nursing Staffing Task. Specifically, the facility stated that nursing staffing, specifically the number of Registered Nurses required for the facility's daily operations, was not accurately documented in the Facility Assessment.The finding is:The facility's policy titled Facility Assessment, last revised 5/8/2025, documented the facility will complete and maintain a facility-wide assessment, which will be reviewed and updated quarterly, annually, or whenever there is any change that would require a substantial modification to any part of the assessment. The assessment will address a range of facility staffing to provide competent support and care for the resident population every day, including weekends and emergencies. A review of the Facility assessment dated [DATE] revealed that the Facility Assessment documented nursing staffing needed to provide competent support and care for the resident population every day, including weekends and emergencies. Specifically, the facility determined each resident unit (1 North, 1 South, 2 North, and 2 South) required zero (0) to one (1) Registered Nurse during the day shift (7:00 AM-3:00 PM). During the evening shift (3:00 PM-11:00 PM) and overnight shift (11:00 PM-7:00 AM), unit 1 North required zero (0) to one (1) Registered Nurse, whereas unit 1 South, 2 North, and 2 South did not require a Registered Nurse. During an interview on 09/03/2025 10:29 AM, the Staffing Coordinator stated that they always scheduled one (1) Registered Nurse on each resident unit (1 North, 1South, 2 North, 2 South) during the day shift (7:00 AM-3:00 PM), and there is always at least one (1) Registered Nurse scheduled during the evening shift (3:00 PM-11:00 PM) and overnight shift (11:00 PM-7:00 AM). The Staffing Coordinator stated that the schedule remained the same during weekends and holidays. During an interview on 09/08/2025 at 10:54 AM, the Director of Nursing Services stated that the facility always has at least one (1) Registered Nurse on any given shift, including the evening shift (3:00 PM-11:00 PM) on a normal operation day. During an interview on 09/08/2025 at 12:46 PM, the Administrator stated the facility always strives to schedule at least one (1) Registered Nurse on any given shift on a day-to-day operation. The Administrator stated that the nursing staffing section in the Facility Assessment represented staffing needs, such as for Registered Nurses, in emergency situations, such as widespread and catastrophic events that could severely impact staffing availability. The Administrator stated that the lower range of the licensed and unlicensed nursing staff number represented the bare minimum the facility required to provide necessary care to all residents during emergency circumstances only. The Administrator stated that they do not expect the lowest number documented in the Facility Assessment, of any nursing staff category (Registered Nurse, Licensed Practical Nurse, and Certified Nursing Assistant), to be considered when scheduling staff on a normal day-to-day operation. The Administrator stated that such a range was documented to provide some wriggle room for the facility to staff under an emergency.10 NYCRR 415.26