

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335734	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/10/2025
NAME OF PROVIDER OR SUPPLIER  Friedwald Center for Rehab and Nursing, L L C		STREET ADDRESS, CITY, STATE, ZIP CODE  475 New Hempstead Road New City, NY 10956	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER  
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and interviews during an abbreviated survey (NY00374854/801166), the facility did not ensure that all participants in the assessment process have the requisite knowledge to complete an accurate assessment. For 4 out of 4 residents (Resident #3, Resident #6, Resident #7, Resident #8) reviewed for assessments. Specifically, (1) Resident #3 who had severe cognitive impairment and was unable to be interviewed had eight trauma informed care assessments completed by the facility Social Worker with a score of zero indicating no evidence of trauma; (2) Resident #6 who had severe cognitive impairment and was unable to be interviewed had eight trauma informed care assessments completed by the facility Social Worker with a score of zero on two assessments and a score of one on six assessment indicating no evidence of trauma; (3) Resident #7 had who had severe cognitive impairment and was unable to be interviewed had twelve trauma informed care assessments completed by the facility Social Worker, with a score of zero indicating no evidence of trauma; (4) Resident #8 who had cognitive impairment and was unable to be interviewed had five trauma informed care assessments completed by the facility Social Worker with a score of zero indicating no evidence of trauma. The completed assessments score did not accurately reflect the residents' trauma exposure or any lingering effects from trauma. The findings are: The facilities Trauma Informed Care policy dated 12/01/2022 documented it is the policy of this facility to provide care and services which, in addition to meeting professional standards, are delivered using approaches which are culturally competent, account for experiences and preferences, and address the needs of trauma survivors by minimizing triggers and/or re-traumatization. The facility will use a multi-pronged approach to identifying a resident's history of trauma, as well as their cultural preferences. This will include asking the resident about triggers that may be stressors or may prompt recall of a previous traumatic event, as well as screening and assessment tools such as the Resident Assessment Instrument (RAI), admission assessment, the history of and physical, the social history/assessment, and others. Resident #3 had diagnoses including but not limited to Alzheimer's disease, Primary Generalized Osteoarthritis and Chronic Kidney Disease. An Annual Minimum Data Set, dated [DATE] documented Resident #3 had severe cognitive impairment. The resident had impairment on both sides to the upper and lower extremities and required a wheelchair for locomotion. The resident required maximal assistance with eating and was dependent for toileting, bed mobility and transfers. Review of an impaired cognition care plan initiated 06/02/2024 documented Resident #3 had cognitive impairment due to Alzheimer's disease and Dementia. Interventions listed included ask yes/no questions in order to determine the resident's needs. Review of the facilities trauma informed assessment revealed it is a resident question-based assessment conducted by the facility Social Worker. Review of Resident #3's chart revealed they had Trauma Informed Care Assessments completed including the following dates: 08/30/2024, 11/27/2024, 02/27/2025, 05/26/2025 and 08/25/2025. The score noted on all assessments reflected 0, indicating there was no evidence of trauma reported by the resident. 2) Resident #6 had diagnoses including but not limited to Multiple Sclerosis, Cerebral Palsy and Aphasia. A Comprehensive Minimum Data Set assessment dated [DATE] documented Resident #6 had severe cognitive impairment. The resident had impairment to the lower extremities on both sides and was dependent for eating, toileting, bed mobility and transfers. Review of an impaired thought process care plan initiated 05/02/2024 documented Resident #6 had disorientation and an inability to follow. Interventions listed included to note cyclic changes in mentation and behavior. Review of Resident #6's chart revealed they had Trauma Informed Care Assessments completed on the following dates: 01/26/2024, 04/19/2024, 07/22/2024, 10/20/2024, 01/18/2024, 02/15/2025, 04/21/2025 and 07/22/2025. 3) Resident #7 had diagnoses including but not limited to Dementia, Cognitive Communication Deficit and End Stage Renal Disease. A Part A Prospective Payment System Discharge Minimum Data Set assessment dated [DATE] documented Resident #7 had severe cognitive impairment. The resident had a gastrostomy tube for nutrition and was dependent for toileting, bed mobility and transfers. Review of an impaired thought process care plan dated 04/15/2025 documented Resident #7 had an impaired thought process related to disorientation and an inability to follow. Interventions listed included assess the full physical status and psychiatric symptoms first and institute plan of care to combat those first. Any change in resident Level of Consciousness indicates area of focus that must be investigated. Review of Resident #7's chart revealed they had Trauma Informed Care Assessments completed on the following dates: 01/14/2024 01/25/2024 03/30/2024 06/28/2024</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and interviews during an abbreviated survey (NY00368065, NY00356980) the facility did not ensure a comprehensive person-centered care plan was implemented for 2 out of 4 residents (Resident #1, Resident #5) reviewed for care planning. Specifically, (1) Resident #1 with a known behavior of refusing care and being non-compliant, had documented refusals of care on three occasions. Review of Resident #1's care plans revealed they did not have a care plan initiated to reflect their refusal behaviors. (2) Resident #5 had a Stage 4 sacral pressure ulcer which resolved on 07/31/2024, the resident was hospitalized on [DATE] and was readmitted to the facility on [DATE] with the Stage 4 sacral pressure ulcer reopened. There was no documented evidence of Resident #5's pressure ulcer care plan being reactivated on readmission. The findings are: The facility Comprehensive Care Plan policy dated 09/24/2024 documented it is the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident comprehensive assessment. 1)Resident #1 admitted to the facility on [DATE] with diagnoses including but not limited to Hepatic Encephalopathy, Essential Hypertension and Osteoarthritis. A Medicare 5-day Minimum Data assessment dated [DATE] documented Resident #1 was cognitively intact. The resident required supervision with eating, maximal assistance with bed mobility and dependent for toileting and transfers. The resident was frequently incontinent of bladder and bowels. Review of Resident #1's nursing progress notes revealed the resident refused care on 01/03/2025, 01/27/2025 and 02/17/2025. Review of Resident #1's care plans revealed the resident did not have a care plan initiated to reflect their refusal of care behavior. During an interview on 09/04/2025 at 1:53 PM Licensed Practical Nurse #1 stated Resident #1 would resist care, and they are not able to force the residents to do anything. Licensed Practical Nurse #1 stated the behavior, and the non-compliance care plans could reflect this behavior. Licensed Practical Nurse #1 stated Resident #1's behavior should have been captured on the behavior care plan the care plans are updated by the nurse manager on the unit. During an interview on 09/08/2025 at 2:10 PM the Director of Nursing stated there should have been a behavior care plan implemented for Resident #1 due to their behaviors. The Director of Nursing stated Resident #1 had refusals of care and this should have been reflected in the resident's care plan. The Director of Nursing stated they are now doing a facility audit of residents' care plans to ensure that if a resident refuses care, then a refusal of care plan is appropriately documented in the resident chart. During a telephone interview on 09/15/2025 at 8:52 AM Registered Nurse #1 stated Resident #1 was non-compliant with a lot of their cares. Registered Nurse #1 stated Resident #1 was their non-compliant resident and many mornings they had to go into the resident's room and encourage/empower the resident to participate in their care and treatment plans. Registered Nurse #1 stated they did not implement a non-compliance care plan for Resident #1 because they did not know that was something they needed to do but they did know of Resident #1's non-compliance. Registered Nurse #1 stated they do not recall the facility having a non-compliance care plan, but Resident #1's non-compliance could have been reflected on a refusal of care or refusal of activities of daily living care plan which was not implemented. 2) Resident #5 admitted to the facility on [DATE] with diagnoses including but not limited to Type 2 Diabetes Mellitus, End Stage Renal Disease and Chronic Obstructive Pulmonary Disease. An Annual Minimum Data Set, dated [DATE] documented Resident #5 had moderate cognitive impairment. The resident requires a wheelchair for locomotion. The resident required moderate assistance with eating, maximal assistance with bed mobility, and dependent for toileting and transfers. The resident was at risk of developing pressure ulcers/injuries and had unhealed pressure ulcers/injuries. The resident had one stage 4 pressure ulcer. Review of a pressure ulcer care plan initiated 03/02/2024 documented Resident #5 had a Stage 4 pressure ulcer or potential for pressure ulcer development related to immobility. Interventions listed included administer treatments as ordered and monitor for effectiveness, assess/record/monitor wound healing weekly, educate resident/family/caregiver as to cause of skin breakdown, inform the resident/family/caregivers of any new areas of skin breakdown. Further review of the pressure ulcer care plan revealed it was resolved as of 07/31/2024. Resident #5 was readmitted to the facility following a hospitalization on 08/21/2024 with the Stage 4 sacral pressure ulcer reopened. There was no documented evidence of a pressure ulcer care plan being initiated for Resident #5's Stage 4 sacral pressure ulcer on readmission to the facility on [DATE]</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and interviews during an abbreviated survey (NY00368065/801164), the facility did not ensure a comprehensive person-centered care plan was implemented for 1 out of 4 residents (Resident #1) reviewed for care planning. Specifically, Resident #1 with a known behavior of refusing care and being non-compliant, had documented refusals of care on three occasions. Review of Resident #1's care plans revealed they did not have a care plan initiated to reflect their refusal behaviors and noncompliance. The findings are: The facility Comprehensive Care Plan policy dated 09/24/2024 documented it is the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident comprehensive assessment. 1)Resident #1 had diagnoses including but not limited to Hepatic Encephalopathy, Essential Hypertension and Osteoarthritis.A Medicare 5-day Minimum Data assessment dated [DATE] documented Resident #1 was cognitively intact. The resident required supervision with eating, maximal assistance with bed mobility and dependent for toileting and transfers. The resident was frequently incontinent of bladder and bowels.Review of Resident #1's nursing progress notes revealed the resident refused care on 01/03/2025, 01/27/2025 and 02/17/2025.Review of Resident #1's care plans revealed the resident did not have a care plan initiated to reflect their refusal of care behavior.During an interview on 09/04/2025 at 1:53 PM, Licensed Practical Nurse #1 stated Resident #1 would resist care, and they are not able to force the residents to do anything. Licensed Practical Nurse #1 stated the behavior, and the non-compliance care plans could reflect this behavior. Licensed Practical Nurse #1 stated Resident #1's behavior should have been captured on the behavior care plan and the nurse manager on the unit is responsible for updating the residents care plans. During an interview on 09/08/2025 at 2:10 PM, the Director of Nursing stated there should have been a behavior care plan implemented for Resident #1 due to their behaviors. The Director of Nursing stated Resident #1 had refusals of care and this should have been reflected in the resident's care plan. The Director of Nursing stated they are now doing a facility audit of the resident's care plans to ensure that if a resident refuses care, then a refusal of care, care plan is appropriately documented in the resident chart. During a telephone interview on 09/15/2025 at 8:52 AM, Registered Nurse #1 stated Resident #1 was non-compliant with a lot of their cares. Registered Nurse #1 stated Resident #1 was their non-compliant resident and many mornings they had to go into the resident's room and encourage/empower the resident to participate in their treatment plans. Registered Nurse #1 stated they did not implement a non-compliance care plan for Resident #1 because they did not know that was something they needed to do. Registered Nurse #1 stated they did not implement the care plan, but they did know of Resident #1's non-compliance. Registered Nurse #1 stated they do not recall the facility having a non-compliance care plan, but Resident #1's non-compliance could have been reflected on a refusal of care or refusal of activities of daily living care plan, and they did not implement these care plans either.10 NYCRR 415.11(c)(1)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>(continued on next page)</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and interviews during an abbreviated survey (NY00368065, NY00374854), 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 for 3 out of 3 residents (Resident #1, Resident #3, Resident #4) reviewed for quality of care. Specifically, (1) Resident #1's representative reported they found Resident #1 covered in urine and feces on multiple occasions. Resident #1 was incontinent and dependent on staff for toileting. Review of Resident #1's certified nurse aide accountability revealed within a 2-month period, there were no signatures indicating toilet use was provided by direct care staff on 37 occasions; (2) Resident #3 is incontinent and dependent on staff for toileting. Review of Resident #3's certified nurse aide accountability record revealed within a 2-month period, there were no signatures indicating toilet use was provided by direct care staff on 26 occasions; (3) Resident #4 was incontinent and dependent on direct care staff for toileting. Review of Resident #4's certified nurse aide accountability record revealed within a 2-month period, there were no signatures indicating toilet use was provided by direct care staff on 16 occasions. The findings are: The facility Activities of Daily Living (ADL) Documentation policy last revised 05/2016 documented the activity of daily living documentation is completed on each shift by the certified nurse aide giving direct care. Toileting is provided as per individual needs of the resident, typically every two to four hours and as needed as the basic standard of care. Certified nurse aides will document whether the resident was continent or incontinent during their shift. 1) Resident #1 was admitted with diagnoses including but not limited to Hepatic Encephalopathy, Essential Hypertension and Osteoarthritis. A Medicare 5-day Minimum Data assessment dated [DATE] documented Resident #1 was cognitively intact. The resident required supervision with eating, maximal assistance with bed mobility and dependent for toileting and transfers. The resident was frequently incontinent of bladder and bowels. Review of an activities of daily living care plan initiated 12/20/2024 documented Resident #1 needed assistance with all tasks. Interventions listed included allow sufficient time to complete each task, assess the ability to bathe, dress, eat and perform toileting activity, assist with toileting and encourage self-care. Review of an incontinence care plan initiated on 01/09/2025 documented Resident #1 was incontinent of bladder and bowel. Interventions listed included observe skin for sign of redness, provide dignity and privacy in management of incontinent episodes, provide emotional support, render perineal skin care as needed and utilize incontinence aids. Review of Resident #1's certified nurse aide accountability for January 2025 revealed toilet use was not signed as being performed on the following dates and times: 7 AM - 3 PM shift: 01/07/2025, 01/12/2025; 3 PM - 11 PM shift: 01/04/2025, 01/05/2025, 01/06/2025, 01/07/2025, 01/11/2025, 01/12/2025, 01/17/2025, 01/19/2025, 01/20/2025, 01/22/2025, 01/25/2025, 01/26/2025, 01/28/2025. Review of Resident #1's certified nurse aide accountability for February 2025 revealed toilet use was not signed as being performed on the following dates and times: 3 PM - 11 PM shift: 02/03/2025, 02/06/2025, 02/08/2025, 02/09/2025, 02/10/2025, 02/16/2025, 02/22/2025, 02/23/2025, 02/24/2025, 02/27/2025. Review of Resident #1's certified nurse aide accountability for March 2025 revealed toilet use was not signed as being performed on the following dates and times: 7 AM - 3 PM shift: 03/13/2025, 03/22/2025; 3 PM - 11 PM shift: 03/03/2025, 03/04/2025, 03/08/2025, 03/13/2025, 03/14/2025, 03/16/2025, 03/18/2025, 03/22/2025, 03/23/2025, 03/24/2025. Further review of Resident #1's certified nurse aide accountability revealed Certified Nurse Aide #1 was assigned Resident #1 on 11 out of the 37 occasions when no signature was documented indicating the toilet use task was performed. During an interview on 09/04/2025 at 2:37 PM, Certified Nurse Aide #1 stated Resident #1 was incontinent at times, but there were times if they were out sitting in the wheelchair they would go to the bathroom and use the toilet. Certified Nurse Aide #1 stated Resident #1 required a one person assist to use the bathroom and sometimes when they arrived on the unit for work, Resident #1 would be soaked in urine, but not feces. Certified Nurse Aide #1 stated they were assigned to Resident #1 on the 11 dates that are missing a signature in the certified nurse aide accountability. Certified Nurse Aide #1 stated if there is no signature in a box on the certified nurse aide accountability, that means the task was not done. Certified Nurse Aide #1 stated sometimes they work short staffed on the units, and they are not able to complete their certified nurse aide accountability and even when they have staff sometimes, they just do not have enough time to complete the accountability. During an interview on 9/5/2025 at 3:24 PM Certified Nurse Aide #4 stated when they arrive for their shift they would find Resident #1 soaked in urine but the resident would let them know if they were</p>		