STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335878	A. Building B. Wing	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Epic Rehabilitation and Nursing at White Plains	120 Church Street White Plains, NY 10601

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews during an abbreviated survey (2686442) the facility did not ensure that residents received treatment and care in accordance with professional standards of practice for one (1) out of three (3) residents (Resident #1) reviewed for consultations. Specifically, Resident #1 had a gastroenterology consult on 08/07/2025 and was recommended to start on the Linzess (a medication for chronic constipation). Licensed Practical Nurse #1 received Resident #1 at the facility following the consultation and documented there were no recommendations. There was no documented evidence that Resident #1 was ever ordered the Linzess (a medication for chronic constipation).The findings are:The facility Orders for Consultants policy dated 07/2019 documented the Attending Physician shall ultimately be responsible for accepting and applying consultation recommendations and orders. All residents who have a consultation will have the consultation report reviewed by the nurse manager/supervisor within 24 to 72 hours of receipt of any recommendations. The Attending Physician/Nurse Practitioner will be notified of any recommendations within 24 hours for review and any orders.Resident #1 admitted to the facility 12/10/2024 with diagnoses including but not limited to Dementia, Schizoaffective disorder and Constipation.A Quarterly Minimum Data Set, dated [DATE] documented Resident #1 was cognitively intact. The resident had impairment on both sides to the upper and lower extremities and used a wheelchair for locomotion. The resident was dependent for eating, toileting, bed mobility and transfers. The resident was always incontinent of bladder and bowel. Review of a constipation risk/bowel management care plan last revised 11/15/2025 documented Resident #1 was at risk due to their impaired physical mobility and age related decreased intestinal motility. The resident had a history of stool impaction and takes senna, docusate sodium, lactulose, and MiraLAX, as well as needed orders for milk of magnesia, Dulcolax suppository, and fleet enema, for treatment of constipation. Interventions listed included administer medication as per Physician's order, monitor bowel elimination daily, monitor efficacy of current bowel regimen, optimize fiber and hydration intake and promote mobility within the resident's capabilities.Review of a gastrointestinal consult done 08/07/2025 documented Resident #1 had a sigmoidoscopy on 12/2024 due to their history of chronic constipation and stercoral colitis with rectal impaction. Resident #1 had been on lactulose in conjunction with the Fleets enema and Dulcolax, while the resident does move their bowels and has been quite distended but no pain. Further review of the gastrointestinal consult revealed the resident received a new order to start Linzess (a medication for chronic constipation) 145 mcg/day to see if it Is more helpful. Resident #1 would be returning to the office in a few months to assess efficacy and if not helping can go back to their original regimen with Linzess (a medication for chronic constipation) added.Review of Resident #1's Physician order and medication administration record revealed they were never ordered to start on Linzess (a medication for chronic constipation).Review of Licensed Practical Nurse #1's progress note dated 08/07/2025 at 7:17 PM documented Resident #1 returned to the facility at 5:00 PM from an appointment accompanied by the certified nurse aide. Documented no recommendations received from the Gastroenterologist and next appointment scheduled for 12/13/2025, Tuesday, at 04:00 PM.During an interview on 12/12/2025 at 01:15 PM the Director of Nursing stated they could not locate the gastroenterologist consult in Resident #1's chart and had to call the Physician's order to obtain it. The Director of Nursing stated the consultation is supposed to be filed in the resident's chart after it is reviewed and addressed by nursing and medical.During a telephone interview on 12/16/2025 at 11:36 AM Licensed Practical Nurse #1 stated when the resident returns from the appointment, they then check the consultation documentation and if there are recommendations they are reviewed with the provider. Licensed Practical Nurse #1 stated the recommendations are documented in a nursing progress note and they would also leave a copy of the consultation for the unit manager to review and be aware. Licensed Practical Nurse #1 stated if there are no recommendations or new orders then the consultation sheet is filed in the resident's chart. Licensed Practical Nurse #1 stated they do not recall what they documented regarding Resident #1's consultation appointment and if there are no new orders then they usually file the documents as there is nothing new on them. Licensed Practical Nurse #1 stated they usually receive the consultation document which is one sheet and they do not recall seeing any orders on Resident #1's consultation sheet or they would have picked up the orders. Licensed Practical Nurse #1 stated the orders would be listed on the consultation document, but it could be that the information was not on the consultation document. Licensed Practical Nurse #1 stated they

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. (continued on next page)

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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 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews during an abbreviated survey (2686442) the facility did not ensure the physician reviewed the resident's total program of care, including medications and treatments, at each visit for 1 out of 3 residents (Resident #1) reviewed for consultations. Specifically, Resident #1, who had a known history of chronic constipation, had a gastrointestinal consultation on 08/07/2025 and was ordered to start on the medication Linzess (a medication for chronic constipation). Nurse Practitioner #2 saw Resident #1 on 08/17/2025 and documented they reviewed the consultation services, but there was no documented evidence of the medication being ordered for the resident. The facility also did not have the consultation documentation on the resident's record or available for review.The findings are:The facility Orders for Consultants policy dated 07/2019 documented Attending Physicians shall ultimately be responsible for accepting and applying consultant recommendations and orders. The Attending Physician will consider the appropriateness of the consultant's recommendations relative to the resident's current condition, risk factors, existing medication regimen, etc and as appropriate approve orders based on consultant recommendations. Resident #1 admitted to the facility 12/10/2024 with diagnoses including but not limited to Dementia, Schizoaffective disorder and Constipation.A Quarterly Minimum Data Set, dated [DATE] documented Resident #1 was cognitively intact. The resident had impairment on both sides to the upper and lower extremities and used a wheelchair for locomotion. The resident was dependent for eating, toileting, bed mobility and transfers. The resident was always incontinent of bladder and bowel. Review of a constipation risk/bowel management care plan last revised 11/15/2025 documented Resident #1 was at risk due to their impaired physical mobility and age related decreased intestinal motility. The resident had a history of stool impaction and takes senna, docusate sodium, lactulose, and MiraLAX, as well as needed orders for milk of magnesia, Dulcolax suppository, and fleet enema, for treatment of constipation. Interventions listed included administer medication as per physician's order, monitor bowel elimination daily, monitor efficacy of current bowel regimen, optimize fiber and hydration intake and promote mobility within the resident's capabilities. Review of a gastrointestinal consult done 08/07/2025 documented Resident #1 had a sigmoidoscopy on 12/2024 due to their history of chronic constipation and stercoral colitis with rectal impaction. Resident #1 had been on lactulose in conjunction with the Fleets enema and Dulcolax, while the resident does move their bowels and has been quite distended but no pain. Further review of the gastrointestinal consult revealed the resident received a new order to start Linzess (a medication for chronic constipation) 145 mcg/day, to see if it Is more helpful. Resident #1 would be returning to the office in a few months to assess efficacy and if not helping can go back to their original regimen with Linzess (a medication for chronic constipation) added. Review of Resident #1's Physician orders and medication administration record revealed they were never ordered to start on the medication Linzess (a medication for chronic constipation).The facility did not have the consultation documentation available for review.During an interview on 12/12/2025 at 1:15 PM the Director of Nursing stated they could not locate the gastroenterologist consult in Resident #1's chart and had to call the Physician's order to obtain it. The Director of Nursing stated the consultation is supposed to be filed in the residents' chart after it is reviewed and addressed by nursing and medical.During a telephone interview on 12/16/2025 at 11:36 AM Licensed Practical Nurse #1 stated when the resident returns from the appointment, they then check the consultation documentation and if there are recommendations, then they are reviewed with the provider. Licensed Practical Nurse #1 stated if there are no recommendations or new orders then the consultation sheet is filed in the resident's chart.During a telephone interview on 12/16/2025 at 01:21 PM Nurse Practitioner #2 stated they recall Resident #1 and the resident always had an issue with constipation. Nurse Practitioner #2 stated Resident #1 had a hospitalization and was recommended to follow up with the Gastroenterologist and based on the resident's history and the hospital recommendation they were ordered to follow up. Nurse Practitioner #2 stated that is why Resident #1 went out for the gastrointestinal consultation on 08/07/2025. Nurse Practitioner #2 stated they do not recall any consults recommending Linzess (a medication for chronic constipation) for Resident #1, because with their history they would have definitely followed the recommendation, and it would have been ordered. Nurse Practitioner #2 stated they do not recall seeing the consultation documentation from the appointment and they review the documentation when the residents return with them. Nurse Practitioner #2 stated they sign off on the consultations for the residents and they have a communication book on each unit where the staff will place