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	05/26/2026

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

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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 - Some Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on record review and interview, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice for two (2) of three (3) residents (Resident #112 and #182) reviewed for change in condition. Specifically, 1) Resident #112 received their daily 9 AM medications at approximately 2:30 PM on 04/13/2026 including the medications Isosorbide Mononitrate and Valsartan (blood pressure pills) for hypertension, Torsemide (water pill) for congestive heart failure, Trelegy Ellipta (inhaler) and Albuterol nebulizer medicine for asthma and 2)for Resident #182 with a history of urinary tract infection and reported complaints of urinary tract symptoms, urine was not collected timely for urinalysis/culture as per the 11/29/2024 physician order. Additionally, there was no documented evidence that the physician was notified when staff were unable to collect the urine on 11/29/2024 and 11/30/2024.The findings include: The July 2019 Policy for Medication Administration Schedule documented that medications shall be administered according to established schedules. Medications are administered according to the following routine schedule: ordered time: daily medications are given at 9:00AM. Medications must be administered within one (1) hour of their prescribed time, unless otherwise specified. The policy titled Catheterization, Intermittent, Female Resident documents to notify the physician of any abnormalities and report other information according to professional standards of practice. 1) Resident #112 had diagnoses including asthma, congestive heart failure, and hypertension. The 04/08/2026 quarterly Minimum Date Set (assessment tool) documented Resident #112 had severely impaired cognition. The Physician Order dated 12/27/2024 documented Valsartan 160 milligram tablet, give 1 tablet by oral route daily for hypertension, Isosorbide Mononitrate extended release 60 milligram, give 1 tablet by oral route daily for hypertension, and Trelegy Ellipta 200 microgram-62.5 microgram-25 microgram powder for inhalation, inhale 1 puff once daily for mild intermittent asthma. The Physician Order dated 10/02/2025 documented Albuterol sulfate 2.5 milligram/3 milliliters (0.083%) solution for nebulization, inhale 3 milliliters (2.5 milligram) by inhalation route four times per day for exercise induced bronchospasm. 10/05/2025 Torsemide 20 milligram, give one tablet by oral route once daily for congestive heart failure, The Care Plan for Asthma last updated 03/04/2026 documented promote compliance with medication regimen. The Care Plan for congestive heart failure last updated 03/04/2026 documented an intervention to administer medications per physician orders. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	The Care Plan for hypertension last updated 03/04/2026 documented notify the provider with elevated blood pressure. The Care Plan for Nebulizer Use/infection control Care Plan last updated 03/05/2026 documented administer nebulized medications as prescribed. The Care Plan for medication last updated 03/09/2026 documented administer medications per Physician/ Nurse Practitioner The April 2026 Medication Administration Record documented Resident #112's 9 AM medications were not administered on 04/13/2026 at 9 AM as ordered. Symbols *^ documented by Licensed Practical Nurse #1 indicated 'not administered' per the Medication Administration Record Legend. The 04/13/2026 Medication Incident Form documented drug omissions including Valsartan, Albuterol, Trelegy Ellipta, Torsemide, and Isosorbide ordered to be administered at 9:00 AM were not given on 04/13/2026. The 04/13/2026 at 2:27 PM Monitoring Tab documented Resident #112's blood pressure was 188/84. The 04/14/26 at 5:31 PM Nurse Practitioner #1 note documented date of service 04/13/26. Resident #112 was seen today for medication review, elevated blood pressure. They were notified at 1:28 PM by Licensed Practical Nurse #1 that Resident #112 did not receive their 9:00 AM medications of Albuterol, Valsartan, Trelegy, Isosorbide. Medications were reviewed by this writer. Seen for elevated blood pressure. Systolic Blood Pressure 188 on 04/13/26 at 2:27 PM. On 05/20/2026 at 12:52 PM during an interview and review of their written statement regarding Resident #112's medication omissions on 04/13/2026, Licensed Practical Nurse # 1 stated they did not administer Resident #112's 9 AM medications as ordered although they were aware that they should have done so. They stated they did not make the nurse manager aware or ask for help. They stated they gave Resident #112 their missed medications around 2:15 PM. On 05/21/2016 at 10:56 AM during an interview, Licensed Practical Nurse Unit Manager #2 stated that medications scheduled for 9AM should be administered between 8AM and 10AM. They stated that the assigned nurse was responsible to assure that the residents received their medications as ordered. They stated that Licensed Practical Nurse #1 should have notified them if they needed help to complete their medication administration as ordered. On 05/21/2026 at 10:40 during an interview, the Assistant Director of Nursing stated that between 1:00 to 1:30 PM on 04/13/2026, they were notified by Resident #112's family that Resident #112 did not receive their 9 AM medications. They stated that Nurse Practitioner #1 was made aware and one-time orders were given to administer the medications and investigation was started regarding the medication omissions. They stated that medications which are ordered to be administered at 9 AM should be administered between 8 AM and 10 AM. They stated it was their expectation that nurses administer medications as ordered. They stated the assigned nurse was responsible for ensuring residents received their medications as ordered. They stated Licensed Practical Nurse Unit Manager #2 was on the unit that day and Licensed Practical Nurse #1 should have notified them if they needed help to complete their medication administration as ordered. They further stated that Licensed Practical Nurse #1 had their cell phone number and could have called them for assistance if Licensed Practical Nurse Unit Manager #2. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	2) Resident # 182 had a diagnosis of hypertension, chronic atrial fibrillation and hyperlipidemia. The Physician Progress Note dated 11/27/2024 at 3:49 PM documented hospital work-up: Daughter notes increased lower abdomen pressure. Urinalysis positive in emergency room. Status post Merrem (antibiotic to treat serious bacterial infection). . The Care Plan for incontinence dated 11/27/2024 documented monitor for signs and symptoms of cystitis such as dysuria, urgency, fever, change in mentation and burning n urination and notify the medical doctor and optimize hydration. The Nursing Progress note written by Infection Preventionist/Staff Educator dated 11/29/2024 at 10:45 AM writer received call from Resident #182's daughter, vocalizing resident complaints of burning in vaginal area. Case discussed with the unit manager and physician. Resident was seen by the physician at bedside with new orders given for urinalysis and culture/sensitivity and to start Pyridium 200 milligram three times daily times two (2) days. Start Pyridium after urinalysis and culture/sensitivity collection. The Physician Order dated 11/29/2024 at 10:51 AM documented urinalysis and culture/sensitivity, may straight catheter as needed. The Physician Progress Note dated 11/29/2024 at 1:02 PM documented urinary tract infection. Commence Pyridium 200 milligrams every 8 hours times two (2) days. Urinalysis and culture/sensitivity. The Physician Order dated 11/29/ 2024 at 5:00 PM documented Pyridium 200 milligram one (1) tablet three (3) times daily x two (2) days for dysuria. The 11/2024 and 12/2024 Medication Administration Record documented Pyridium was administered as per physician order. The Nursing Progress Note dated 11/29/ 2024 at 9:53 PM documented that Resident #182 started on Pyridium 200 milligram related to dysuria. Resident #182 noted with blood in their brief. Registered Nurse Supervisor #50 and Physician # 23 notified. Monitor for another episode. Resident #182 is scheduled for urine collection for urinalysis and urine culture. Resident #182 is incontinent. Unable to obtain urine specimen, writer endorsed to next shift. The Nursing Progress Note dated 12/1/2024 at 9:08 AM documented Resident #182 remains without episodes of hematuria so far this shift. Continues Pyridium three (3) times a day for management of urinary discomfort as per daughter. Resident #182 denies urinary burning currently. Reminded Resident #182 of urine specimen collection and to call for staff to assist with specimen collection. The Nursing Progress Note dated 12/1/2024 at 11:07 PM documented Resident #182 is alert and responsive. Urine was collected for urinalysis and culture and stored in the 3rd floor refrigerator, pending collection. Continue to monitor. There was no documented evidence to indicate that urine was collected as per the 11/29/2024 physician order prior to 12/01/2024. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	There was no documented evidence that the physician was notified when staff were unable to collect the urine on 11/29/2024 and 11/30/2024. The Nurse Practitioner Progress Note dated 12/02/2024 at 10:31 PM documented labs: urinalysis with microscopy positive. The Physician Order dated 12/02/2024 documented Pyridium 100mg twice daily x two (2) days for dysuria. The 12/2024 Medication Administration Record documented Pyridium 100mg was administered as per physician order on 12/02/2024, 12/03/2024 and 12/04/2024. The Physician Progress Note dated 12/04/2024 at 2:17 PM documented proteus mirabilis (bacteria) greater than 100K. The admission Minimum Data Set (assessment tool) dated 12/03/2024 documented Resident #182 had moderate cognitive impairment, was incontinent of bowel and bladder and required substantial/maximal assistance with toileting hygiene. During an interview on 5/26/2026 at 1:00 PM the Medical Director stated if urine needed to be collected on a Friday, they would usually put in a stat order. They stated if the resident was symptomatic, they would follow up on the status of the urine. Additionally, they stated four (4) days was not a reasonable amount of time to wait on collection of urinalysis and urine culture. They stated this case was an outlier. During an interview on 5/26/2026 at 1:25 PM the Director of Nursing stated if the resident was symptomatic, the urine should have gone out quicker. 10 New York Code Rules Regulations 415.12

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on record review and interviews, the facility failed to ensure they implemented interventions correctly and consistently including adequate supervision consistent with the Resident's needs, goals, care plan, and physician's orders to prevent accidents for one (1) of five (5) residents (Resident #112) reviewed for accidents. Specifically, there was no documented evidence that every one-hour monitoring when in bed was implemented as per physician order prior to an 8/25/2025 fall, no documented evidence that Resident #112 was always kept in a supervised area when awake as per comprehensive care plan prior to an 8/31/2025 fall, and no documented evidence that Resident #112 was out of bed to their wheelchair on the 11:00 PM to 7:00 AM shift as per comprehensive care plan prior to a 03/27/2026 fall. Additionally, the Director of Nursing did not investigate whether or not interventions were consistently implemented to prevent falls. The findings included: The Policy for Falls-Clinical Protocol dated 7/2019 documented, the physician will help identify individuals with a history of falls and risk factors for falling. The staff and physicians will identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling. If underlying causes cannot be readily identified or corrected, staff will try various relevant interventions based on assessment of the nature or category of falling, until falling reduces or stops or until the reason is identified for its continuation. The staff and physicians will monitor and document the individual's response to interventions intended to reduce falls or the consequences of falling. Resident #112 had diagnoses that included asthma, heart failure, and non-Alzheimer's dementia.The Physician Order dated 12/27/2024 documented monitor Resident #112 every hour when in bed, which populated to the Medication Administration Record.The 7/06/2025 annual Minimum Data Set (assessment tool) documented Resident #112 was cognitively impaired and had 2 or more falls with no injury since admission or prior assessment. Resident #112 required supervision with rolling in bed, sitting to standing, chair to bed and toilet transfers, and with ambulation 50 feet, and was dependent with locomotion in their wheelchair.The Care Plan for falls updated on 7/21/2025 documented keep Resident #112 in supervised area when awake, close monitoring when asleep.The 8/11/2025 Briggs Fall Risk Evaluation documented total score of 20, High Risk!The 8/25/2025 Incident & Accident Report documented Resident #112 had an unwitnessed fall and was observed by staff lying on the floor mat next to their bed on 8/25/2025 at 10PM. The statement written by Licensed Practical Nurse #3 documented they last provided care to Resident #112 at 8:15 PM. The statement written by Certified Nurse Aide #5 documented they last provided care to Resident #112 at 7:30 PM and did not document the last time they saw Resident #112 prior to the incidentThe August 2025 Medication Administration Record documented by Licensed Practical Nurse #3 indicated Resident #112 was monitored every hour when in bed during the 3:00 PM-11:00 PM shift on 8/25/2025.The 8/25/2025 Briggs Fall Risk Evaluation documented total score of 24, High Risk.The 8/31/2025 Incident/Accident Report documented Resident #112 had an unwitnessed fall and was observed by staff lying on their right side on the floor by their wheelchair in their room on 8/31/2025 at 6AM. Resident #112 stated they fell and hit their head. The statement documented by Registered Nurse #4 documented that Resident #112 was brought in their wheelchair to the nursing station area by Certified Nurse Aide #6, at 5:50 AM, and Resident #112 wheeled themselves back to their room and fell.The Care Plan for falls was updated on documented 1/1/2026, ensure Resident #112 is out of bed to their wheelchair on the 11PM to 7AM shift.The 1/06/2026 quarterly Minimum Data Set documented Resident #112 was cognitively impaired and had 2 or more falls with no injury since admission or prior assessment. Resident #112 required supervision with rolling in bed, sitting to standing, chair to bed and toilet transfers, and with ambulation 50 feet, and was dependent with locomotion in their wheelchair.The 3/13/2026 Briggs Fall Risk Evaluation documented total score of 18, High Risk.The 3/27/2026 Incident/Accident Report documented Resident #112 had an (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	unwitnessed fall and was observed by staff on the floor by their bed on 3/27/2026 at 7:40 AM. There was no documented evidence as to the reason Resident #112 was not out of bed to their wheelchair on the 11PM to 7AM shift and in a supervised area.On 5/21/2026 at 12:58 PM during an interview the Director of Nursing stated that Licensed Practical Nurse #3 signed the Medication Administration Record documenting they monitored Resident #112 every hour, however Licensed Practical Nurse #3 documented in their written statement that they last saw Resident #112 at 8:15 PM which was one hour and 45 minutes prior to Resident #112's fall at 10PM. They stated they had not investigated whether or not the intervention to monitor Resident #112 every hour had been implemented.On 05/21/2026 at 5:45 PM during an interview Licensed Practical Nurse #3 stated they last provided care to Resident #112 on 08/25/2025 at 8:15 PM when they administered their nebulizer treatment per their handwritten statement. They stated they were responsible to monitor Resident #112 every hour per the physician order, but they had to administer medications to other residents down the hall. They stated their handwritten statement was accurate.On 05/21/2026 at 3:51 PM during an interview Registered Nurse #4 stated that Resident #112 was brought to the nurse's station on 08/31/2025 by Certified Nurse Aide #6 to be supervised for safety, however Resident #112 wheeled themself to their room without staff observing them. They stated they were administering medications at that time. They stated they gave clear verbal instructions and a written assignment sheet to the Certified Nurse Aides as to which residents needed to be taken out of bed on their shift and stated that the Certified Nurse Aides were responsible to monitor those residents for safety.On 05/21/2026 at 4:13 PM during interview Certified Nurse Aide #6 stated the nurse, and certified nurse aides should take turns supervising residents for safety.On 05/21/2026 at 4:32 PM during interview the Director of Nursing stated their expectation was that the staff use a team approach to supervise residents. They stated staff should not have left Resident #112 unsupervised. They stated staff was responsible for supervising Resident #112 when they were out of bed. They stated they did not investigate how Resident #112 was able to get to their room unattended, while they should have been supervised by staff.On 05/21/2026 at 5:34 PM during a follow-up interview regarding Resident #112's 8/31/2026 fall, the Director of Nursing stated there were no documented instructions as to how the staff should monitor Resident #112 for supervision / safety.On 05/21/2026 at 5:34 PM during an interview, the Director of Nursing stated Resident #112 should have been assisted out of bed on the 11PM to 7AM shift for supervision on 3/27/2026. They stated they did not know why Resident #112 was in bed at 7:40 AM on 3/27/2026. They stated that on 1/01/2026 the care plan intervention documented to assist Resident #112 out of bed on the 11PM to 7AM shift, however on 3/27/2026 there was no documentation as to the reason why Resident #112 was still in bed after 7AM. The Director of Nursing stated the intervention to assist Resident #112 out of bed for supervision was not populated to the Medication Administration Record and it was not documented in the Resident Nursing Instructions for the Certified Nurse Aides. The Director of Nursing stated they did not investigate the reason that Resident #112 was in bed at 7:40 AM.On 05/22/2026 at 8:32 AM during interview regarding Resident #112's fall on 3/27/2026, Certified Nurse Aide #7 stated they had worked the overnight shift from 3/26/2026 to 3/27/2026. They stated they were aware to get Resident #112 out of bed at around 6:30 AM and bring them to the seating area outside the nursing station for supervision and they were aware they were responsible to supervise Resident #112 while the resident was at the nursing station. They stated they did not remember if they had assisted Resident #112 out of bed on that date and stated they had not been asked to write a statement.On 05/22/2026 at 9AM during an interview with Registered Nurse #8 regarding Resident #112's fall on 3/27/2026, they stated they had worked the overnight shift from 3/26/2026 to 3/27/2026. They stated they were aware that Resident #112 should be assisted to get out of bed at around 6:30 AM on night shift. Registered Nurse #8 stated they would have written a note if Resident #112 had refused to get out of bed on the night shift. They stated they did not know why Resident #112 was in bed after 7AM on 3/27/2026, and they had not been asked to write a statement.On 05/22/2026 at 1:35 PM interview with Licensed Practical Nurse (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Unit Manager #2 regarding Resident #112's fall on 3/27/2026, they stated Resident #112 was sleeping when they rounded on the unit at 7:15 AM. They stated the 1/01/2026 care plan intervention documented ensure Resident #112 was out of bed to wheelchair on 11PM to 7AM shift. They stated they did not know why the 3/27/2026 Incident / Accident Report did not include documentation regarding Resident #112 being in bed at 7:40 AM.10 New York Code Rules Regulation 415.12(h)(2)