STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335022	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sands Point Center for Health and Rehabilitation	1440 Port Washington Blvd Port Washington, NY 11050

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on record review and interviews the facility did not ensure that there was sufficient nursing staff to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This was identified on five (5) (Unit 1 Center, Unit 1 North, Unit 1 West, Unit 2 Center, and Unit 2 West) of five (5) units reviewed for the Sufficient Nursing Staffing Task. Specifically, the Payroll-Based Journal Staffing Data Report indicated the facility had excessively low weekend staffing for Quarter one (1) through Quarter four (4) for Fiscal Year 2025 and for Quarter one (1) for Fiscal Year 2026. A random sampling of the facility nursing staffing assignments did not reflect the staffing numbers as indicated in the facility assessment for the Certified Nursing Assistants and Registered Nurses.This is a repeat deficiency.The finding is:The Centers for Medicare and Medicaid Services Payroll-Based Journal Staffing Data Report for Fiscal Year 2025 Quarter One (1) (October 1-December 31), Quarter Two (2) (January 1-March 31), Quarter Three (3) (April 1-June 30), Quarter Four (4) (July 1-Spetember 30); and for Fiscal Year 2026 Quarter One (1) (October 1-December 31) indicated the facility triggered for the Metric of Excessively low weekend staffing based on facility submitted staffing data.The facility assessment last reviewed 12/04/2025 documented the bed capacity of 180 with an average daily census of 138.4 based on the last 12 months resident census. The facility assessment documented the following staffing plan for the weekend (Saturday to Sunday): For the day shift (7:00 AM to 3:00 PM):Unit 1 North required two (2) Registered nurses or one (1) Registered Nurse and (1) Licensed Practical Nurse, and three (3) to four (4) Certified Nursing Assistants.Unit 1 Center required one (1) Registered Nurse or one (1) Licensed Practical Nurse, and three (3) to four (4) Certified Nursing Assistants.Unit 1 [NAME] required one (1) Registered Nurse or one (1) Licensed Practical Nurse, and three (3) to four (4) Certified Nursing Assistants.Unit 2 Center required one (1) Registered Nurse or one (1) Licensed Practical Nurse, and three (3) to four (4) Certified Nursing Assistants.Unit 2 [NAME] required one (1) Registered Nurse or one (1) Licensed Practical Nurse, and three (3) to four (4) Certified Nursing Assistants.For the evening shift (3:00 PM to 11:00 PM):Unit 1 North required two (2) Registered nurses or one (1) Registered Nurse and (1) Licensed Practical Nurse, and three (3) to four (4) Certified Nursing Assistants.Unit 1 Center required one (1) Registered Nurse or one (1) Licensed Practical Nurse, and three (3) to four (4) Certified Nursing Assistants.Unit 1 [NAME] required one (1) Registered Nurse or one (1) Licensed Practical Nurse, and three (3) to four (4) Certified Nursing Assistants.Unit 2 Center required one (1) Registered Nurse or one (1) Licensed Practical Nurse, and three (3) to four (4) Certified Nursing Assistants.Unit 2 [NAME] required one (1) Registered Nurse or one (1) Licensed Practical Nurse, and three (3) to four (4) Certified Nursing Assistants.For the night shift (11:00 PM to 7:00 AM):Unit 1 North required two (2) Registered nurses or one (1) Registered Nurse and (1) Licensed Practical Nurse, and two (2) Certified Nursing Assistants.Unit 1 Center required one (1) Registered Nurse or one (1) Licensed Practical Nurse, and two (2) Certified Nursing Assistants.Unit 1 [NAME] required one (1) Registered Nurse or one (1) Licensed Practical Nurse, and two (2) Certified Nursing Assistants.Unit 2 Center required one (1) Registered Nurse or one (1) Licensed Practical Nurse, and two (2) Certified Nursing Assistants.Unit 2 [NAME] required one (1) (continued on next page)

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

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Registered Nurse or one (1) Licensed Practical Nurse, and two (2) Certified Nursing Assistants.The facility assessment documented an additional Registered Nurse Supervisor was required for each shift on the weekends.The facility's bed capacity by unit was as follows: Unit 1 Center had a bed capacity of 38, Unit 1 North had a bed capacity of 35, Unit 1 [NAME] had a bed capacity of 35, Unit 2 Center had a bed capacity of 37, and Unit 2 [NAME] had a bed capacity of 35.A review of the 7:00 AM to 3:00 PM staffing schedule from 10/05/2024 to 12/28/2025 indicated the following:On 11/29/2025 there were only two (2) Certified Nursing Assistants on Unit 1 North with a census of 31 residents.On 10/19/2024,12/28/2024, 12/29/2024, 09/07/2025, 09/20/2025, and 9/21/2025 there were only two (2) Certified Nursing Assistants on Unit 1 [NAME] with unit census ranging from 28 to 31 residents.On 4/20/2025, 6/29/25 there were two (2) Certified Nursing Assistants on Unit 2 Center with census of 32 on 04/20/2025 and a census of 31 on 06/29/25.On 10/05/2024, 10/19/2024, 01/25/2025, 03/23/2025, 04/06/2025, 04/19/2025, 04/20/25, 05/03/2025, 05/04/2025, 06/15/2025, 07/272025, 08/09/2025, 08/2025, 09/07/2025, 09/20/2025 and 12/27/2025 there were only two (2) Certified Nursing Assistants on Unit 2 [NAME] with census ranging from 25 to 31 residents.A review of the 3:00 PM to 11:00 PM staffing schedule from 10/05/2024 to 12/28/2025 indicated the following:On 04/19/2025, 05/03/2025, and 06/28/2025 there were only two (2) Certified Nursing Assistants on Unit 1 Center with census ranging from 26 to 28.On 04/06/2025 there were only two (2) Certified Nursing Assistants on Unit 1 [NAME] with a census of 29.On 01/25/2025 there were two (2) Certified Nursing Assistants on Unit 2 [NAME] with a unit census of 25.A review of the 11:00 PM to 7:00 AM schedule from 10/05/2024 to 12/28/2025 indicated the following:On 11/17/2024, 04/19/2025, 08/10/2025, and 09/21/2025 there was only one (1) Certified Nursing Assistant on Unit 1 Center with a census ranging from 23 to 26On 11/03/ 2024 the night shift Registered Nurse Supervisor was covering Unit 1 Center and there was only one Licensed Practical Nurse on Unit 1 North; the census on Unit 1 North was 29.On 07/26/2025 there was only one (1) Certified Nursing Assistant on Unit 1 [NAME] with a census of 28.On 11/30/2024 there was only one (1) Certified Nursing Assistant on Unit 2 Center with a census of 33.On 11/16/2024, there was only one (1) Certified Nursing Assistant on Unit 2 [NAME] with a census of 20.On 05/04/2025, the night shift Registered Nurse Supervisor was the covering nurse for Unit 1 Center and there was no nurse on Unit 2 West. Unit 2 [NAME] had a Census of 28.During an interview on 03/11/2026 at 10:49 AM, the Staffing Coordinator stated the facility has had low staffing on the weekends this past year especially with Certified Nursing Assistants. The facility has increased efforts to recruit more nursing staff to improve weekend coverage. The Staffing Coordinator stated they try to staff the units with four Certified Nursing Assistants; however if there is a staffing problems there should at least be three Certified Nursing Assistants assigned to each unit.During an interview on 03/13/2026 at 10:17 AM, the Director of Nursing Services stated when they first started working at the facility in September 2025, nursing staff was calling out frequently. The Director of Nursing Services stated in the past year the facility also had concerns related to staff retention. The Director of Nursing Services stated when there were not enough nurses on the weekend, sometimes the Registered Nurse Supervisor would assist with unit nursing coverage and, for example, on 05/04/2025 during the 11:00 PM to 7:00 AM shift, one nurse from Unit 1 North was moved to Unit 2 [NAME] for nurse coverage, leaving Unit 1 North with only one (1) Registered Nurse. The Director of Nursing Services stated Unit 1 North is a subacute unit with higher-acuity residents which was why two (2) nurses were required each shift for Unit 1 North.During an interview on 03/13/2025 at 10:46 AM, the Administrator stated they have been employed at the facility for about a year and a half and was aware the facility historically has had nurse staffing shortage. The Administrator stated they continue to have concerns with nursing staff coverage on the weekends due to the location of the facility as it may be difficult for many staff to reach the facility via public transportation. The Administrator the facility is putting efforts into resolving the staffing shortage by offering overtime pay, financial incentives such as gift cards and bonuses, increased visibility online, and by utilizing staffing agencies.10 NYCRR 415.13(a)(1)(i-iii)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on record review, and staff interviews the facility did not ensure it established and maintained an infection prevention and control program designed to provide a safe and sanitary environment and to help prevent the development, and transmission of communicable diseases and infections. This was identified during the Infection Control Task. Specifically, the facility did not provide documented evidence of testing all portions of the potable water system for Legionnaires' and other Waterborne pathogens. The facility did not provide documents describing the building's water distribution systems to identify legionella sampling points.The findings are: The facility's undated Engineering & Facilities titled Section: Engineering Management Subject: Legionella Tessing did not document a description of the water distribution systems in the building. Additionally, the policy did not include a flow diagram of the water distribution systems in the building and did not identify legionella water sampling points in the building. The Laboratory Certificate of Analysis documented water samples were collected from four hot water sinks on 12/16/2025 and the results were reported on 12/17/2025 with no Legionella isolates. There was no documented evidence that the facility identified other areas where there is a high probability of opportunistic pathogens in the building's water distribution systems. During an interview on 03/13/2026 at 10:50AM, the Director of Plant Operations and Environmental Services stated that they were not aware of testing the cold-water potable water distribution system in the building and that the water management plan would be amended to identify additional sampling points in the building. They further stated that the water management plan would be amended to include a description of the water distribution systems in the building and that flow diagrams would also be included. During an interview on 03/13/2026 at 11:30 AM, the Administrator stated the current Water Management Plan would be reviewed and revised to include a full description of the water distribution systems in the building with flow diagrams, and to identify additional legionella sampling points. 10 NYCRR 415.19(a)(1-3)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews the facility did not ensure a resident assessment was completed to accurately reflect each resident's status. This was identified for one (1) of two (2) residents reviewed for Tube Feeding. Specifically, Resident #1 was admitted to the facility with a percutaneous endoscopic gastrostomy (PEG) tube (a type of feeding tube inserted into the stomach). The admission Minimum Data Set assessment dated [DATE] did not reflect the resident had a feeding tube while a resident. The finding is:A facility policy titled MDS last reviewed 10/01/2025 documented the Minimum Data Set 3.0 process requires input form the health care team to complete the designated areas in a timely and accurate fashion in accordance with state and federal regulations. The Minimum Data Set assessment must be conducted or coordinated by a Registered Nurse who will sign and certify the assessment is completed. The Registered Nurse assessment coordinator is not certifying the accuracy of portions of the assessment that were completed by other health professionals. Resident #1 was admitted with diagnoses including gastrostomy (an artificial external opening into the stomach), malignant neoplasm of the esophagus (a cancerous tumor of the esophagus), and dysphagia (difficulty with swallowing). The admission Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status Score of 8, indicating the resident had moderate cognitive impairment. The Minimum Data Set Assessment documented the resident did not have a feeding tube while in the facility. A Hospital and Community Patient Review Instrument dated 01/16/2026 documented the resident had a percutaneous endoscopic gastrostomy (PEG) tube placed on 01/12/2026. A comprehensive care plan titled Gastrointestinal dated 01/16/2026 documented the resident was at risk for gastrointestinal distress related to conditions including the presence of a gastrotomy tube with tube feeding. A comprehensive care plan titled Aspiration/Dysphagia dated 01/26/2026 interventions including to apply treatment to the gastrostomy site as per physician's order and check patency and placement of feeding tube as per facility protocol. A physician's order dated 01/16/2026 and discontinued on 01/22/2026 documented to administer two (2) cans of Jevity 1.5 formula via a percutaneous endoscopic gastrostomy (PEG) tube at 5:00 AM, 1:00 PM, and 8:00 PM. Administer 100 milliliters free water flush before and after bolus tube feeding. A physician's order dated 01/22/2026 and discontinued on 01/29/2026 documented to administer two (2) cans of Jevity 1.5 formula bolus with gravity via a percutaneous endoscopic gastrostomy (PEG) tube twice a day. Administer a water flush of 100 milliliters before and after each bolus feed. During an interview on 03/12/2026 at 10:59 AM, the Dietician stated they were responsible for completing Section K (Swallowing/Nutritional Status) of the Resident #1's admission Minimum Data Set Assessment. The Dietician stated the Minimum Data Set assessment dated [DATE] for Resident #1 should have indicated resident having the feeding tube on the assessment because Resident #1 had a feeding tube during the assessment period. The Dietician stated the omission of Resident #1's feeding tube status in section K0502 of the admission Minimum Data Set assessment was an error. During an interview on 03/13/2026 at 8:38 AM, the Minimum Data Set Assessment Nurse stated they were responsible for signing for the completion of Resident #1's admission Minimum Data Set Assessment. The Minimum Data Set Assessment Nurse stated when they signed for completion under Section Z (Assessment Administration) of the assessment, they were only verifying completion and not the accuracy of each section of the assessment. During an interview on 03/13/2026 at 11:16 AM, the Director of Nursing Services stated each staff completing the sections of the Minimum Data Set assessment is responsible to ensure accuracy of the information entered. The Director of Nursing Services stated the nurse signing for completion should ensure the assessment is completed accurately. The Director of Nursing Services stated Resident #1's admission Minimum Data Set assessment should have accurately reflected the resident had a feeding tube while a resident during the assessment period. 10 NYCRR 415.11(b)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, during the abbreviated survey (2729430), the facility did not ensure that each resident receives adequate supervision to prevent accidents. This was identified for two (2) (Resident #115 and Resident #41) of four (4) residents reviewed for accidents. Specifically, on 1/28/2026 Resident #41 exhibited anger when Resident #115 approached Resident #41 in the dining room. Certified Nursing Aide #3 identified Resident #41's trigger and removed Resident #115 from the dining room; however, did not notify the nurse of Resident #41's behavior or the need to monitor Resident #115 to prevent them from going near Resident #41. Shortly afterwards, Resident #115 returned to the dining room and reapproached Resident #41. Resident #41 got angrier and hit Resident #115 on the head with an empty meal tray. The finding is:The facility policy titled Abuse and Neglect Prevention defines a Resident to Resident altercation as a physical or verbal act between two residents with or without resulting injury, and further specifies that for altercations where the aggressor is cognitively impaired, he/she must be able to possess intent to harm. The policy's Education/Orientation section indicated that staff training includes appropriate interventions to address aggressive and/or catastrophic reactions of residents, and recognition of conditions that may place residents at risk for becoming victims. -Resident #115 was admitted with diagnoses including Alzheimer's disease, major depressive disorder and anxiety disorder. The annual Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 7, indicating the resident had severely impaired cognition. Resident #115 did not exhibit any behaviors and used a wheelchair for locomotion. Resident #115's care plan for Abuse, Mistreatment and Neglect, initiated on 01/15/2025 and last revised on 01/29/2026 documented the resident presented with agitation and verbal outbursts at times. Interventions included that medical, nursing, and social work staff will explore both medical and environmental factors that might cause behaviors and communicate findings to all involved staff.-Resident #41 was admitted with diagnoses including traumatic brain injury (diagnosis clinically associated with impaired impulse control, emotional disinhibition, and reduced capacity for behavioral self-regulation), seizures, and hemiplegia (weakness) of the left dominant side. The annual Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 12, indicating the resident had moderately impaired cognition. The Minimum Data Set assessment documented the resident had periods of forgetfulness and confusion. Resident #41 required assistance with all activities of daily living. Resident #41 used a wheelchair for locomotion. Resident #41's care plan for Abuse, Mistreatment and Neglect, initiated on 08/03/2023 and last updated 01/06/26 documented the resident was at risk of being abused or mistreated by others and had the potential to abuse or mistreat others. Interventions included monitoring mood and provide early intervention on changes observed.An Incident Report for Resident #115 dated 01/29/2026 documented on 01/28/2026, Certified Nursing Aide #3 was monitoring the 2W dayroom shortly before 05:45 PM. Resident #41 appeared to be annoyed when Resident #115 entered the room. Certified Nursing Aide #3 then escorted Resident #115 to their room and immediately returned to the dining room. Resident #115 subsequently wheeled themself back to the dayroom and approached Resident #41 at their table. Resident #41subsequently picked up an empty meal tray and struck Resident #115 on their head. Certified Nursing Aide #3 was present in the dayroom at the time but was unable to intervene due to being on the other side of the dining room where they were assisting another resident. Resident #115 was assessed and had no visible injuries and the Physician was notified. The incident report dated 1/29/2026 for Resident #41 documented Resident #41 struck Resident #115 with an empty dinner tray in the 2W dining room/dayroom on 01/28/2026 at approximately 5:45 PM. Resident #41 was sent to the hospital for evaluation and returned back to the facility the next day with no recommendations. During an interview on 03/12/2026 at 11:37 AM, (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Certified Nursing Aide #3 stated they were covering the dining room on 1/28/2026 when the altercation between Resident #41 and Resident #115 occurred. Prior to the incident, Resident #41 appeared upset when Resident #115 entered the dining room and that is why they (Certified Nursing Aide #3) escorted Resident #115 to their room and returned to the dining room. Certified Nursing Aide #3 stated they did not notify the nurse or another Certified Nursing Assistant of Resident #41 being upset at Resident #115. Soon afterwards, Resident #115 returned to the dining room and went over to Resident #41's table. Resident #41 became angry and hit Resident #115 on the head with an empty meal tray. Certified Nursing Aide #3 stated they were tending to another resident in the dining room and were too far from Resident #41 therefore could not reach Resident #41 on time to prevent the incident. During an interview on 03/12/2026 at 11:50 AM, the Assistant Director of Nursing Services/Risk Manager stated that they completed the incident investigation related to the incident between Resident #41 and Resident #115. As per Certified Nursing Aide #3 Resident #41 appeared annoyed with the presence of Resident #115. Certified Nursing Aide #3 escorted Resident #115 to their room. Resident #115 subsequently wheeled themself back to the dayroom. Resident #41 picked up a tray and struck Resident #115. Certified Nursing Aide #3 was present in the dayroom but was unable to intervene on time due to distance. The Assistant Director of Nursing Services stated that the altercation could have been prevented had the certified nursing aide (#3) closely monitored Resident #115 after redirecting them to their room or by informing other nursing staff of the suspected potential for an altercation between the two residents. Resident #115 should have been supervised to ensure they were not near Resident #41 to prevent an avoidable accident.During an interview on 03/12/2026 at 11:59 AM, the Director of Nursing stated that residents' interactions should always be monitored by staff to avert potential altercations. The Director of Nursing stated the incident could have been prevented if Resident #115 was monitored after being redirected to their room. During an interview on 03/12/2026 at 12:10 PM, the Administrator stated that the incident may have been prevented if Resident #115 received close supervision. Resident #115 should have been monitored by staff after being identified as a potential trigger for Resident #41 in the dining room.10 NYCRR 415.12(h)(2)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, record review, and interviews, the facility did not ensure that each resident was free from significant medication errors. This was identified for one (1) (Resident #15) of five (5) residents observed during medication administration task. Specifically, during the medication administration observation for Resident #15, Licensed Practical Nurse #1 crushed the extended-release (designed to release the medication slowly over time) Metoprolol Succinate tablet (a medication which slows the heart rate and reduces cardiac workload). The directions on the extended-release Metoprolol Succinate blister pack indicated Swallow Whole, Do Not Chew Or Crush.The finding is:The facility policy titled Medication Pass, revised 01/2025, documented medications are administered safely and timely as per the physician's orders. Know the diagnosis and indication for every medication. Remember the six rights of medication pass: Right Resident, Right Drug, Right Dose, Right Dosage Form, Right Route, and Right Time.Resident #15 was admitted with diagnoses including hypertension, heart failure, and diabetes mellitus. The 02/07/2026 Quarterly Minimum Data Set assessment documented a Brief Interview for Mental Status score of 11, indicating the resident had moderate cognitive impairment. The Minimum Data Set documented that the resident did not have a swallowing disorder.A physician's order dated 02/19/2026, renewed on 03/09/2026, documented diet order: no concentrated sweets/no added salt, regular consistency, thin liquids (a non-restrictive, standard diet with no modifications).During the medication pass observation on 03/10/2026 at 8:55 AM, Licensed Practical Nurse #1 prepared the following medications for Resident #15 as ordered by the Physician:Aspirin 81 milligram chewable tablet, chew 1 tablet by oral route once daily for atherosclerotic heart disease of native coronary artery.Januvia 25 milligram tablet, give 1 tablet by oral route once daily for Type 2 diabetes mellitus.Lasix 40 milligram tablet, give 2 tablets (80 milligrams) by oral route once daily in the morning for hypertensive heart disease with heart failure.Metoprolol succinate extended release 25 milligram tablet, extended release 24 hour, give 1 tablet by oral route once daily for essential hypertension.Potassium chloride extended release 20 milliequivalent tablet, extended release, give 1 tablet by oral route 2 times per day for hypokalemia (low potassium).Licensed Practical Nurse #1 stated the resident has a problem swallowing and then diluted the extended-release potassium chloride tablet in the water. The nurse also crushed all of the other tablets together, including the extended-release Metoprolol Succinate tablet, in a plastic bag with a pill crusher. The directions on the extended-release Metoprolol Succinate blister pack indicated Swallow Whole, Do Not Chew Or Crush. Licensed Practical Nurse #1 put the crushed medications in the apple sauce and administered the medications to the resident along with the potassium chloride that was diluted in a cup of water.A review of the medical record revealed there was no current physician's order to crush medications for Resident #15.During an interview on 03/10/2026 at 10:35 AM, Licensed Practical Nurse #1 stated the Metoprolol Succinate medication label on the blister pack indicated directions to Not Crush the medication. Licensed Practical Nurse #1 stated Resident #15 has trouble swallowing, that is why they diluted the potassium chloride tablet in the water and crushed the other medications.During an interview on 03/10/2026 at 10:50 AM, the Director of Nursing Services stated there should be a physician's order in place to crush medications. The Director of Nursing Services stated extended-release Metoprolol Succinate tablets should not be crushed and this is a very significant medication error. The Director of Nursing Services stated if the resident was having trouble swallowing, the nurse should have reported that to the Physician.A physician's order dated 03/10/2026 at 10:52 AM, documented may crush appropriate medications to facilitate administration, if applicable.During an interview on 03/10/2026 at 2:50 PM, Physician #1 stated the order to crush medications as appropriate should have been in place before the nurse crushed the medications for Resident #15. It is not recommended to crush the extended-release Metoprolol Succinate medication. If an extended-release Metoprolol Succinate medication was crushed, the resident should have been monitored closely for symptoms including low blood pressure and low heart (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	rate.During an interview on 03/11/2026 at 1:05 PM, Pharmacist #1 stated crushing the extended-release Metoprolol Succinate tablet changes the medication's mechanism of action. The extended-release tablet is designed to release the medication over time, and crushing the medication will cause all the medication to be released at once which could cause low blood pressure or slowed heart rate.10 NYCRR 415.12(m)(2)

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews the facility did not ensure that drugs and biologicals used in the facility were labelled with currently accepted professional principles for one (1) (Resident #127) of two residents reviewed for tube feeding, and for one (1) (Resident #33) of one (1) resident reviewed for Hydration. Specifically, 1) on 03/09/2026, Resident #127 was in bed receiving the physician ordered tube feeding; however, the tube feeding bottle did not have the resident name, room number, start time of the tube feeding, flow rate, or name of nurse who started the tube feeding; and 2) Resident #33 had a physician's order to receive intravenous hydration. On two separate observations the intravenous fluid (administered directly into a vein) bag was not labeled. The findings are: 1) The facility policy titled Enteral Feeding, Ready-to-Hang Feedings, dated 01/2025, documented under procedure: complete all information on the ready-to-hang container label (resident name, room, date, start time, and rate). [NAME] feeding set with start date and time. Proper identification and dating are essential for resident safety. Resident #127 was admitted with diagnoses including cerebrovascular accident, seizure disorder, and dysphagia (difficulty swallowing). The 03/01/2026 Quarterly Minimum Data Set assessment documented a Brief Interview of Mental Status score of 5, indicating the resident had severe cognitive impairment; had signs and symptoms of possible swallowing disorder, including holding food in mouth/cheeks or residual food in mouth after meals; and used a feeding tube while a resident. A physician's order dated 02/23/2026 renewed on 03/11/2026 documented continuous tube feeding - using pump kit, formula: Osmolite 1.5, at 55 milliliters per hour, for 17 hours/day. Start at 4:00 PM and remove at 9:00 AM or until completed. On 03/09/2026 at 8:43 AM Resident #127 was in bed and was receiving the Osmolite 1.5 tube feeding formula. The feeding pump indicated the flow rate of 55 milliliters per hour and there was a small amount of formula left in the bottle. The tube feeding bottle did not have a resident label. There was no resident name, room number, start time of the feeding, rate, or name of nurse who started the feeding. During an interview on 03/09/2026 at 8:47 AM, Registered Nurse #1 (the unit manager) observed the tube feeding bottle and stated the tube feeding bottle should be labelled with resident name, room number, start time of the feeding, rate, or name of nurse who started the feeding. Registered Nurse #1 stated the tube feeding was started at 4:00 PM the previous afternoon (03/08/2026) by the evening nurse, Registered Nurse #2 , and was due to be completed at 9:00 AM today. During an interview on 03/12/2026 at 12:11 PM, Registered Nurse #2 (the medication nurse) stated they worked on 03/08/2026, on the 3:00 PM-11:00 PM shift and the following 11:00 PM – 7:00 AM shift. Registered Nurse #2 stated they were busy and forgot to place the resident label on the tube feeding bottle for Resident #127. It was a mistake; I should have labelled the tube feeding bottle. During an interview on 03/12/2026 at 12:23 PM, the Director of Nursing Services stated the nurse must place a resident label on the tube feeding bottle to ensure the right resident is getting the right (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335022	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sands Point Center for Health and Rehabilitation	1440 Port Washington Blvd Port Washington, NY 11050

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tube feeding formula, right rate, and right volume. 2) The facility's Intravenous (IV) Therapy policy, last revised in January 2025, documented to administer intravenous therapy via an infusion pump, where possible. The intravenous label should indicate resident's name, type of solution, start date and time, flow rate, and the nurse's initials. Resident #33 was admitted with diagnoses of anemia (lack of healthy red blood cells to carry oxygen), adult failure to thrive (presence of one or more medication conditions that lead to progressive decline) and heart failure. The Annual Minimum Data Set (MDS) assessment dated [DATE] documented Resident #33 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severely impaired cognition. The Minimum Data Set assessment documented Resident #58 had intravenous access but did not receive intravenous medication in the past 14 days of the look-back period. The Comprehensive Care Plan for Intravenous therapy dated 12/18/2025 documented the resident has a midline (a catheter inserted into a deep upper arm vein) intravenous catheter. Interventions included monitoring intravenous site every shift and as needed, monitor signs of dehydration, and to administer medications as ordered by the Physician. The Physician's order dated 03/06/2026 documented to administer Dextrose 5% and 0.45% sodium chloride, intravenous solution, at 30 cubic centimeters (cc) per hour every shift for adult failure to thrive. During an observation on 03/09/2026 at 08:38 AM, the resident was in bed and was receiving Dextrose 5% intravenous solution into the resident's left arm at 30 cubic centimeters/hour. The 1000 cubic centimeter capacity bag had 100 cubic centimeters of fluid remaining. The intravenous solution bag was observed without any label to indicate resident information or the date and time the intravenous solution was initiated. Resident #33 was alert but unable to answer any questions. A private companion was at the resident's bedside and stated that Resident #33 has been receiving intravenous fluids since the weekend. During an observation on 03/09/2026 at 01:00 PM, Resident #33 was in bed with a 1000 cubic centimeter capacity Dextrose 5% intravenous solution bag at the bedside with 910 cubic centimeters of fluid remaining. The intravenous solution was being infused into the resident's left upper and inner arm. The infusion pump was connected and displayed the intravenous tubing was set at 30 cubic centimeters/hour, and 90 cubic centimeters had been infused. The intravenous solution bag was observed without any label to indicate the resident information or the day and time the intravenous solution was initiated. During an interview on 03/09/2026 at 01:30 PM, Registered Nurse #5 stated that they replaced a new intravenous solution bag this morning when the previous bag was completed. Registered Nurse #5 stated they should have labeled the intravenous bag with the resident's name and room number when they hung the new intravenous solution bag. Registered Nurse #5 stated that they do not always indicate the start date or the start time on the intravenous solution bag because the infusion rate is set on the infusion pump. During an interview on 03/11/2026 at 12:33 PM, Licensed Practical Nurse #3, who was the unit manager, stated that resident's name, room number, day and time of administration must be documented on the intravenous solution bag. Licensed Practical Nurse #3 stated that start time must (continued on next page)

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	335022	A. Building B. Wing	03/13/2026

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	be indicated on the label to monitor the amount of fluid administered to the residents. During an interview on 03/12/2026 at 03:24 PM, the Director of Nursing Service stated that nursing staff should ensure the label on the intravenous solution bag must include resident's name, room number, information about the medicine, and start date and time the fluid was administered. 10 NYCRR 415.18(e)(1-4)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335022	A. Building B. Wing	03/13/2026

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, record review, and interviews, the facility did not ensure that medical records were maintained in accordance with professional standards of practice and were complete and accurately documented. This was identified for one (1) (Resident #127) of two (2) residents reviewed for respiratory care. Specifically, Resident #127 had an as-needed order for oxygen administration. On multiple occasions the resident was administered the as-needed oxygen, but there was no documentation in the medical record that the oxygen was administered as per the physician's orders.The finding is:The untitled facility policy addressing oxygen delivery, dated 12/2025, documented it is the policy of the facility that residents requiring supplemental oxygen have it administered as per the physician's order. If determined, the Physician will order oxygen therapy either continuous or as needed. Any signs of distress or change in resident's condition will be reported to the Physician.The facility policy, titled Medication Pass Policy, revised 01/2025, documented when as-needed (PRN) medications are administered, documentation is to include: date and time of administration; symptoms for which the medication was given; results achieved; signature or initials of person recording administration, and signature or initials of person recording results.Resident #127 was admitted with diagnoses including cerebrovascular accident, seizure disorder, and chronic obstructive pulmonary disease. The 03/01/2026 Quarterly Minimum Data Set assessment documented a Brief Interview for Mental Status score of 5, indicating the resident had severe cognitive impairment. The resident had shortness of breath or trouble breathing when lying flat and received oxygen therapy while a resident.A physician's order dated 01/22/2026 documented oxygen at 2 liters per minute via nasal cannula as needed. Keep oxygen saturation (the percentage of oxygen-carrying hemoglobin in the blood) greater than 90%.During an observation on 03/09/2026 at 8:43 AM, Resident #127 was in bed receiving oxygen therapy via a nasal cannula. The oxygen flow rate on the oxygen concentrator was set at 2 liters per minute.During an observation on 03/10/2026 at 8:30 AM, Resident #127 was in bed receiving oxygen therapy via a nasal cannula. The oxygen flow rate on the oxygen concentrator was set at 2 liters per minute. During an observation and interview on 03/11/2026 at 10:40 AM Resident #127 was in their room in their wheelchair. The resident was not interviewable. A private aide was present in the room. The resident was receiving oxygen via nasal cannula. The private aide stated sometimes the resident has trouble breathing and that is why the resident is receiving oxygen therapy. Review of the March 2026 Treatment Administration Record revealed no nursing signatures documenting that the as-needed oxygen was administered to Resident #127 for the month of March 2026. During an interview on 03/11/2026 at 11:45 AM, Registered Nurse #1 (the unit manager) stated this morning they put the oxygen on the resident because the resident was agitated during the morning care and became short of breath and their oxygen saturation dropped to 88% and did not get a chance to document. Registered Nurse #1 stated the nurses are supposed to document when the oxygen therapy is administered. During an interview on 03/11/2026 12:50 PM, Registered Nurse Staff Development #1 stated the nurses should sign off in the treatment administration record for oxygen administration. The reason why the oxygen was given as needed must be documented so the Physician or Pulmonologist will clearly see how often the as-needed oxygen is being administered. During an interview on 03/11/2026 at 2:55 PM, the Director of Nursing Services stated the nurses should be documenting in the treatment administration record and progress notes when oxygen therapy is administered for a resident.10 NYCRR 415.22(a)(1-4)