STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335040	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Forest Care Center for Rehab & Healthcare	9 Hilaire Drive Huntington, NY 11743

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 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. (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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F 0689 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 observation, record review and staff interviews during an abbreviated Survey (800072) initiated on 08/19/2025 and completed on 09/11/2025, the facility did not ensure that a resident maintained, to the extent possible, acceptable parameters of nutritional and hydration status. Specifically, Resident #1's weight decreased from 190 pounds in July 2025 to 168 pounds in August 2025, a total weight loss of 22 pounds in one month. This loss of over 11.5% exceeds the Centers for Medicare & Medicaid Services (CMS) guideline for a significant weight loss of 5% in 30 days. Furthermore, there is no documented evidence that the dietician implemented new nutritional interventions to address this decline prior to the survey entrance.The finding is:The policy titled Significant Weight Change/ Unplanned weight loss dated 10/22/2024 documented significant weight change is indicated by -5% in 30 days -7.5% in 90 days -10% in 180 days. Further documented when a weight loss is detected a healthcare team will do the following weekly and monthly weights for 2 weeks to determine if weigh loss remains significant. Review food intake record and estimate oral intake, initiate a 3-day caloric count, identify possible medical and psychosocial causes of inadequate nutrient intake interview resident for information and update food preferences monitor intake of foods and fluids and check laboratory data as necessary.Resident #1 is a [AGE] year-old male admitted to the facility 8/18/23. Medical diagnosis includes dementia anxiety disorder Diabetes type 2. Minimum Data Set, dated [DATE] documents Brief Interview Mental Status score of 5. Resident requires supervision or touching assistance for shower and bathing hygiene and eating. The Minimum Data Set further documents a weight of 190 pounds 74 height.The Comprehensive Care Plan titled Nutrition dated 08/01/2022 with the last revision dated 7/16/2025 documented as the goal: Resident will have no significant weight changes through the review date and the resident will consume greater than 50% of meals snacks and supplements provided through the review date. The approaches included but were not limited to: Review food/fluid preferences, menu/alternates available, and monitor intake via nutrition log.The Facilities weigh record documents the following weights: 05/01/2025 187.4 pounds06/02/2025 192.4 pounds07/01/2025 190.2 pounds08/04/2025 168.8 poundsPhysician order documented No concentrated sweets diet regular texture thin consistency, Boost glucose control three times a day for supplement 240cc three times daily effective 03/27/2025.A Nutrition progress note dated 7/16/2025 documented Resident is at risk for nutrition compromise related to dementia anxiety follow up of weigh 3/27/202185 pounds 3.2% with decrease. The note further documented improved appetite 06/25/2025.A draft physician note dated 07/25/2025 documented pt referred for evaluation for progressive weight loss weight of 185 pounds and Body mass index 23.8, weight of 212 in 2023. The note further documented Metformin was discontinued and started Invokana.A Nurse practitioner progress note dated 08/13/2025 documented follow up resident visit note for weight variance/weight gain. The note further documented: Weight Variance with mild weight loss, Dietitian following for Management and Continue with Low Fat Low Chol/No Added Salt /no Concentrated Sweet, Regular texture, thin consistency diet and GLUCERNA Supplement and well tolerated well. Dietitian following for monitoring of weight status. Weight 171.6 LBS 08/07/25 from 192.4 LBS on 06/02/25 from 187.4 LBS 5/01/25.Continue Bowel Regimen and monitor for BM. Continued Medication including Melatonin at hours of sleet for insomnia with improvement. There are no documented notes from the Dietician or change in plan of care thru 8/18/2025.During an observation with the state agency the resident weigh on 08/19/2025 resident was weight on a standing scale read 171 pounds. During an observation of lunch resident was observed to be served in his room a meal tray which included rice, beans chicken taco milk and a fruit cup. The resident did not consume any of the meal. During observation resident was offered a sandwich which he was observed to eat half of half the sandwich 25%.The Certified Nurses Accountability was reviewed for July 1-July 31, 2025, and documented resident received setup or clean up assistant with most meals on the 7-3 and 3-11 shift. The Accountability sheet further documented on average resident consumed 51-75% of meals offered during the day 9:00 AM, 1:00PM and 5:00PM.During an interview conducted on 8/19/2025 with Resident #1 they stated they have lost quite a bit of weight because their pants are falling off and their shirts do not fit. Resident #1 stated he does not like the food, so he does not eat it. Resident #1 stated that staff gives him a sandwich but thinks it might not be enough. Resident #1 does not remember if he is provided with a supplement or how often but states he does not drink much. During an interview conducted on 8/18/2025 at 2 pm with Certified Nursing Assistant #1 they stated they are the primary aid for resident #1. They stated that resident #1 has not been

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interviews during an abbreviated Survey (800072) initiated on 08/19/2025 and completed on 09/11/2025, the facility did not ensure the resident environment remained free of accident hazards for one (1) of two resident floors (Floor 2) reviewed. Specifically, Floor 2, a locked dementia care unit had a bottle of Isopropyl Alcohol 91% and over 30 pills of brand multivitamins accessible to residents.Findings include:Isopropyl alcohol also known as rubbing alcohol is a clear, colorless liquid. Widely used as a first aid antiseptic, surface disinfectant and solvent, it is highly flammable, and potentially toxic if absorbed through the skin, inhaled as vapor or ingested. It can lead to dizziness headache nausea, central nervous system depression and loss of consciousnessResident #1 is a [AGE] year-old male admitted to the facility 8/18/23. Medical diagnosis includes dementia anxiety disorder Diabetes type 2. Minimum Data Set, dated [DATE] documents Brief Interview Mental Status score of 5.A comprehensive care plan titled cognition dated 8/2022 documented resident has short and long term memory loss. Interventions include ensure resident safety. There were no care plans observed for self administration. There is no documented order that resident may self administer medication.During an observation 08/19/2025 of Resident #1's bedroom, the bedside table was observed with a bottle containing over 30 tablets of brand name multivitamin tablets. Additionally, the resident was observed with 91% isopropyl alcohol 16 ounces about 90% full. During an interview conducted with Resident #1 on 8/19/2025 at 10:30 AM they stated they did not know what the bottle of pills on the bedside table were or where they came from. They further stated possibly a family member brought them to eat because they were concerned about their weigh loss. When asked about the bottle of isopropyl alcohol Resident #1 replied it was water.During an interview on 8/19/2025 at 11:53 AM, License Practical Nurse #1 stated they are the primary nurse for Resident #1. Licensed Practical Nurse #1 stated she provided the resident with their medication in their room in the morning. Licensed Practical Nurse #1 stated the Resident should not have the alcohol or the bottle of vitamins at the bedside. She further stated she does not know where the resident got it from and would remove it immediately.During an interview on 08/19/2025 at 2:00 PM the Director of Nursing stated the second floor is a designated dementia unit. They further stated there should not be any medication or alcohol at the resident's bedside.10 NYCRR 415. 12(h)(1)(2)