STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335044	A. Building B. Wing	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Far Rockaway Center for Rehabilitation and Nursing	13 11 Virginia Street Far Rockaway, NY 11691

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review during survey, the facility failed to ensure that preadmission screening for individuals with a mental disorder and individuals with intellectual disability was conducted prior to their admission to the facility. This was identified for one (Resident #74) of 37 23 residents reviewed for Pre-admission Screening and Resident Review (a federal requirement to ensure that residents were not inappropriately placed in a skilled nursing facility). Specifically, Resident # 74 was initially admitted to the facility on [DATE], and had an inaccurate and incomplete Level I Pre-admission Screening and Resident Review screen dated 7/31/2024. Items 23 through 26 of the Preadmission Screening and Resident Review form were not completed prior to admission. Response to Items 23 through 26 would determine if a Level II evaluation was required.The findings include: The facility's policy and procedure titled Pre-admission Screening and Resident Review (PASARR) last reviewed in October 2025 documented that centralized admission will obtain the completed Level I screen for all admissions prior to being accepted to and arrival at the facility. Upon admission, the social worker will validate completion of the Level I Screen and Level II Preadmission Screening and Resident Review (if required), and the documents will be maintained in the clinical record. Resident #74 was admitted with diagnoses of dementia, bipolar disorder, and fracture of the right femur (the thigh bone). The admission Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 13, which indicated the resident had intact cognition. The Minimum Data Set Pre-admission Screening and Resident Review section documented that Resident #74 was not currently considered by the state level II Pre-admission Screening and Resident Review process to have a serious mental illness, intellectual disability, or other related conditions. The Pre-admission Screening and Resident Review screen dated 07/31/2024 was reviewed on 03/31/2026. The screen documented that the resident does not have a dementia diagnosis (item 22). Responses to four (4) screening questions (item 23 through 26) were indicated but not answered. Items 23 through 26 of the Preadmission Screening and Resident Review form include the following: Level I Review for Possible Mental Illness, and Level I Review for Possible Mental Retardation/Developmental Disability. Guideline on the form indicated If item 23 or any of items 24-26 are marked YES, proceed to Categorical Determinations (items 27-30). If item 23 and all of items 24-26 are marked NO, proceed to Patient/Resident/Person Disposition (item 36). During an interview on 04/01/2026 at 09:17AM, the Director of admission stated that the facility's offsite central admission department determine the admission eligibility and receive all resident pre-admission packages when resident gets admitted to the facility. The Director of admission stated they receive and upload the resident's pre-admission documentations into the electronic medical record and they do not review the content of the documents. During an interview on 04/01/2026 09:56AM, the Director of Social Services stated they were responsible for ensuring the Pre admission Screening and Resident Review form was received and completed accurately. The Director of Social Services stated that the Pre admission Screening and Resident Review form should have been completed accurately to determine if the resident is appropriately placed in the facility for care and services they require. The Director of Social Services stated Resident #74's Pre-admission Screening and Resident Review (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	screen should have been completed prior to their admission to this facility. The Director of Social services stated the screen should be completed accurately. During an interview on 04/03/2026 at 09:19AM, the Director of Nursing Services stated the Pre-admission Screening and Resident Review screen should been thoroughly reviewed to ensure responses were completed accurately and appropriately. The Administrator stated that Resident #74's Pre-admission Screening and Resident Review screen should have been completed prior to their (Resident #74) admission to determine if resident is appropriately placed in the facility. 10 NYCRR415.11(e)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews during survey, the facility failed to ensure that a comprehensive person-centered care plan was implemented for each resident that included measurable objectives and timeframes to meet each resident's medical and nursing needs. This was identified for one (1) (Resident #5) of three (3) residents reviewed for positioning/mobility. Specifically, the facility did not ensure implementation of care plan interventions for Resident #5 related to bilateral upper extremity contractures, which included the use of hand positioning devices. Resident #5 was observed on multiple occasions without the required intervention in place, and there was no documented evidence of refusal of care.The findings include: The facility policy and procedure titled Care Plans - Comprehensive, last reviewed 08/02/2024, indicated that a comprehensive, person-centered care plan, including measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs, is to be developed and implemented for each resident. The Interdisciplinary Team reviews and updates the care plan: at least quarterly, with scheduled quarterly Minimum Data Set assessments and when the desired outcome is not met. The residents have the right to refuse to participate in the development of their care plan and medical and nursing treatments. Such refusals will be documented in the residents' clinical record in accordance with the established policies. Resident #5 was admitted with diagnoses including major depressive disorder, generalized muscle weakness, and other abnormalities of gain and mobility. The annual Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status of 14, indicating cognitively intact. Resident #5 did not exhibit any behaviors or refusal of care and had a functional limitation in range of motion in the upper extremity (shoulder, elbow, wrist, hand), bilaterally. A comprehensive care plan titled Bilateral Upper Extremities contractures, created on 5/14/2025.The interventions included the resident uses bilateral gauze to prevent further closure of each hand. A care plan titled Limited physical mobility related to Bilateral Upper Extremity Contractures dated 01/13/2026 documented intervention including adaptive devices, right hand palm guard (a protective splint designed to prevent fingers from digging into the palm) to be removed during hygiene/activities of daily living/range of motion grooming, left hand palm guard to be removed during hygiene/ Activities of daily living/range of motion grooming. During an observation on 03/30/2026 at 10:06 AM, Resident #5 was observed lying in bed without any hand positioning device in place. Both hands were observed closed in a fisted position, with fingers tightly closed into the palms. Resident #5 was unable to open their hands independently. The resident was not wearing a palm guard or gauze rolls on their hands. During an observation on 04/01/2026 at 11:14 AM, Resident #5 was again observed in bed without the use of a palm guard or the gauze roll in place. Both hands remained closed in a fist position. During an observation on 04/02/2026 at 10:55 AM, Resident #5 was observed in bed without any hand positioning device in place. A palm guard was noted on the resident's nightstand. At that time, Resident #5 stated they were willing to use the device. Resident #5 did not state why they had not been utilizing it. The Certified Nursing Assistant Kardex (instructions provided to certified nursing assistants for resident care) indicated adaptive devices: right and left hand palm guard, to be removed during hygiene, activities of daily living, and grooming. During an interview on 04/01/2026 at 11:29 AM, Certified Nursing Assistant #1 stated they always make sure to wash the insides of Resident #5's contracted hands and keep the nails clean and cut. Certified Nursing Assistant #1 stated they had not provided morning care to Resident #5 yet and were not aware the resident did not have the hand device in place. During an interview on 04/01/2026 at 11:46 AM, Licensed Practical Nurse Unit Manager #2 stated Resident #5 has a history of refusing the use of the palm guards for the contracted hands. Licensed Practical Nurse Unit Manager #2 stated they did not know that Resident #5 had been recently refusing the use of the adaptive device. A review of the electronic medical record from (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	03/30/2026 to date 04/01/2026 did not reflect any documentation of refusal of care. During an interview on 04/01/2026 at 11:59 AM, the Director of Rehabilitation Services stated that the staff should follow the plan of care for each resident. Resident #5 should have had the palm guard or the gauze rolls applied as per their plan of care at all times except for hygiene and skin care. During an interview on 04/03/2026 at 1:56 PM, the Director of Nursing Services stated residents have the right to refuse treatment; however, the refusals must be documented in the resident's medical record. The Director of Nursing Services stated the staff should have ensured interventions related to the use of the palm guard and the gauze rolls were followed for Resident #20. NYCRR 10 NYCRR 415.11(c)(1)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to ensure services provided or arranged by the facility met the current professional standards of quality. This was identified for one (1) (Resident #20) of one resident reviewed for tube feeding. Specifically, Resident #20 was not administered the full amount of 1200 milliliters of feeding formula as per physician orders. Additionally, Licensed Practical Nurse #2, the 7:00 AM-3:00 PM nurse did not confirm and erroneously documented that Resident #20 received the total amount of their enteral feed. Cross Reference: F693-Tube feeding ManagementThe findings include:The facility policy titled, Enteral Feeding Administration last reviewed in February 2026 documented to verify healthcare provider order for the enteral tube feeding including type, method of administration, rate, volume and eneteral tube flushes. Upon completion, disconnect the feeding tube and clamp the enteral tube. Document date/time of procedure, type and amount of enteral feeding and flush as applicable, verification of enteral tube placement and patency, resident's tolerance or complication and notification to healthcare provider of the complications in the [resident's] clinical record.Resident #20 was admitted with diagnoses of dysphagia (difficulty swallowing), gastrostomy status (creation of an artificial external opening into the stomach), and adult failure to thrive. The admission Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 6, which indicated the resident had severely impaired cognition. Resident #20 had parental or intravenous feeding and mechanically altered diet and received 25 percent or less of their total calories and 501 cubic centimeters or more fluid through tube feeding per day (at this time the resident did not have a gastrostomy tube for feeding).The physician's order dated 03/25/2026 documented to administer Isosource 1.5 via enteral tube at 65 milliliters/hour to begin at 18:00 (6:00PM) for a total volume of 1200 milliliters to be delivered every evening shift and every shift for neurogenic dysphagia. Verify infusion every shift. Keep the head of the bed elevated at least 30 degrees during administration. Stop the tube feeding when total volume of 1200 milliliters is infused. Verify with pump setting that the total volume has been delivered. Document the total volume infused.The Medication Administration Audit Report for March 2026 documented that Licensed Practical Nurse #3 started the enteral feed on 03/30/2026 at 05:04 PM. The formula should be infused for 18.5 hours, that is 11:30 AM on 03/31/2026, to meet the 1200 milliliters threshold.During an observation on 03/31/2026 at 09:07 AM, Resident #20 was observed in bed. The infusion pole was observed at bedside. No feeding bag was hanging on the pole, and the resident was not connected to a feeding tube. The electronic infusion pump screen was off.A review of the Medication Administration Record for March 2026 on 03/31/2026 at 09:16 AM documented that Licensed Practical Nurse # 2, the unit manager, confirmed by their signatures (initials) that a total volume of 1200 milliliters of enteral feed was delivered to Resident #20. During an interview on 03/31/2026 at 09:30 AM, Licensed Practical Nurse #2 stated that prior to documenting in the Medication Administration Record, they did not verify that Resident #20's enteral feed was completed. Licensed Practical Nurse #2 stated that they observed that Resident #20's feeding set up was put away and the infusion pump was turned off, therefore they assumed the feeding was completed. Licensed Practical Nurse # 2 stated that Resident #20's enteral feeding should still be infusing at this hour(09:30 AM) as per physican's order and they should have checked the pump setting to ensure that the total volume has been delivered.During a re-interview on 03/31/2026 at 11:31 AM, Licensed Practical Nurse # 2 stated that they reviewed the pump setting and calculated that Resident #20 received only 800 milliliters out of the total 1200 milliliters enteral feed ordered by the Physician. Licensed Practical Nurse # 2 stated they should not have documented the feeding was completed without verifying first.During an interview on 03/31/2026 at 10:15 AM, Licensed Practical Nurse # 4, the 11:00 PM - 7:00 AM shift nurse, stated they were the assigned nurse for Resident #20 on 03/30/2026 into 03/31/2026. Resident #20's feeding pump was alarming several times during the (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	night. Licensed Practical Nurse # 4 had to pause, flush, and resume the enteral feeding several times throughout the night. Licensed Practical Nurse # 4 stated that they had to discontinue Resident #20's enteral feeding prematurely to silence the tube feeding pump alarm. Licensed Practical Nurse # 4 stated that they called the scheduled day shift nurse on the phone to notify them to follow-up and to resume Resident #20's feed when their shift starts. Licensed Practical Nurse # 4 was not able to speak to the scheduled nurse in person. Licensed Practical Nurse # 4 stated they did not notify the night nursing supervisor about Resident #20 not receiving their required amount of the enteral feeding.During an interview on 04/03/2026 at 09:12 AM, the Director of Nursing Services stated the night nurse should have notified the night shift nursing supervisor that Resident #20's feeding was stopped and the total enteral feeding amount was not met. The Director of Nursing Services stated that without confirming, nursing staff should not have documented that Resident #20's feed was completed.10 NYCRR 415.11(c)(3)(i)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews during survey, the facility failed to ensure that a resident who is fed by enteral means receives the appropriate treatment, care, and services to prevent complications of enteral feeding. This was identified for one (1) (Resident #20) of one resident reviewed for tube feeding. Specifically, Resident #20 has a physician's order to receive 1200 milliliters of enteral feed (the delivery of nutrients through a feeding tube directly into the stomach or small intestine) daily in the evenings. On 03/31/2026, Resident #20 did not receive the required amount of the enteral feed as Licensed Practical Nurse # 4, the 11:00 PM - 7:00AM shift nurse, discontinued the tube feeding prior to completion of the required amount. The enteral feed was not resumed until concern was brought forward by the survey team. The findings include:The facility policy titled, Enteral Feeding Administration last reviewed in February 2026 documented to verify healthcare provider order for the enteral tube feeding including type, method of administration, rate, volume and enteral tube flushes. Verify enteral formula for continuous feeding and follow the manufacturer's instruction for use (MIFU) for the recommended hang time. Hang feeding bag on infusion pole. If using electronic feeding pump, clear pump of previous volume infusion and set flow rate/total volume and start the pump. Monitor for tolerance or complications and report to healthcare provider for additional orders. Upon completion, disconnect the feeding tube and clamp the enteral tube. Document date/time of procedure, type and amount of enteral feeding and flush as applicable, verification of enteral tube placement and patency, resident's tolerance or complication and notification to healthcare provider of the complications in the [resident's] clinical record. Resident #20 was admitted with diagnoses of dysphagia (difficulty swallowing), gastrostomy status (creation of an artificial external opening into the stomach), and adult failure to thrive. The admission Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 6, which indicated the resident had severely impaired cognition. Resident #20 had parental or intravenous feeding and mechanically altered diet and received 25 percent or less of their total calories and 501 cubic centimeters or more fluid through tube (enteral) feeding per day (at this time the resident did not have a gastrostomy tube for feeding). The Comprehensive Care Plan for tube feeding dated 3/13/2026 documented that Resident #20 requires tube feeding related to dysphagia and failure to thrive. Interventions included administering tube feeding and water flushes as per the Registered Dietitian's recommendation and physician's orders; monitor/document/report the following which included but are not limited to: aspirations, tube dislodged, infection at tube site, and tube dysfunction or malfunction.The physician's order dated 03/25/2026 documented to administer Isosource 1.5 via enteral tube at 65 milliliters/hour to begin at 18:00 (6:00PM) for a total volume of 1200 milliliters to be delivered every evening shift and every shift for neurogenic dysphagia. Verify infusion every shift. Keep the head of the bed elevated at least 30 degrees during administration. Stop the tube feeding when total volume of 1200 milliliters is infused. Verify with pump setting that the total volume has been delivered. Document the total volume infused. The Medication Administration Audit Report for March 2026 documented that Licensed Practical Nurse #3 started the enteral feed on 03/30/2026 at 05:04 PM. The formula should be infused for 18.5 hours, that is 11:30 AM on 03/31/2026, to meet the 1200 milliliters threshold. During an observation on 03/31/2026 at 09:07 AM, Resident #20 was observed in bed. The infusion pole was observed at bedside. No feeding bag was hanging on the pole, and the resident was not connected to a feeding tube. The electronic infusion pump screen was off.A review of the Medication Administration Record for March 2026 on 03/31/2026 at 09:16 AM documented that Licensed Practical Nurse # 2, the unit manager, confirmed by their signatures (initials) that a total volume of 1200 milliliters of enteral feed was delivered to Resident #20. During an interview on 03/31/2026 at 09:30 AM, Licensed Practical Nurse # 2 stated that prior to (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documenting in the Medication Administration Record they did not verify that the resident had received the total amount of the enteral feeding as per the physician's order. Licensed Practical Nurse #2 stated that on 03/31/2026, at the start of their shift, the Resident #20's enteral feeding set up was put away and the infusion pump was turned off, they assumed the tube feeding was completed. Licensed Practical Nurse # 2 stated that Resident #20's enteral feeding should have been still infusing at this hour (09:30 AM), as per physician's order. Licensed Practical Nurse #2 stated that prior to signing the Medication Administration record, they should have checked the infusion pump setting to ensure that Resident #20 received the 1200 milliliters of the tube feeding formula. During a re-interview on 03/31/2026 at 11:31 AM, Licensed Practical Nurse # 2 stated that they reviewed the enteral feeding pump settings and calculated that Resident #20 had only received 800 milliliters out of the total 1200 milliliters of enteral feed ordered by the physician. Licensed Practical Nurse # 2 stated that the day shift medication nurse is usually responsible to verify and ensure the total amount of feeding is administered as per the physician's orders. Licensed Practical Nurse #2 stated that the scheduled day medication nurse called out this morning, so they had to cover the unit until the replacement nurse came in. Licensed Practical Nurse # 2 stated they should not have documented the feeding was completed without first verifying that Resident #20 received the required amount of the tube feeding formula. During an interview on 03/31/2026 at 10:15 AM, Licensed Practical Nurse # 4, the 11:00 PM - 7:00 AM shift nurse, stated they were the assigned nurse for Resident #20 on 03/30/2026 into 03/31/2026. Resident #20's feeding pump was alarming several times during the night. Licensed Practical Nurse # 4 had to pause, flush, and resume the enteral feeding several times throughout the night. Licensed Practical Nurse # 4 stated that they had to discontinue Resident #20's enteral feeding prematurely to silence the tube feeding pump alarm. Licensed Practical Nurse # 4 stated that they called the scheduled day shift nurse on the phone to notify them to follow-up and to resume Resident #20's feed when their shift starts. Licensed Practical Nurse # 4 was not able to speak to the scheduled nurse in person. Licensed Practical Nurse # 4 stated they did not notify the night nursing supervisor about Resident #20 not receiving their required amount of the enteral feeding. During an interview on 03/31/2026 at 03:20PM, the Registered Dietitian stated Resident #20 returned to the facility from the hospital status post tube feeding placement on 03/13/2026. The Registered Dietitian stated the enteral feeding amount was started at a lower amount for better bowel tolerance. The feeding amount was last updated on 03/25/2026 to current feeding rate and volume. The Registered Dietitian stated current enteral feeding order provided 1800 calories per day which meets the resident's energy needs. The Registered Dietitian stated that Resident #20 should receive 1200 milliliters of 1.5 Isosource enteral formula to meet their nutrition needs. During an interview on 04/03/2026 at 09:12 AM, the Director of Nursing Services stated the night nurse should have notified the night shift nursing supervisor that Resident #20's feeding was stopped and the total enteral feeding amount was not met. The Director of Nursing Services stated that without confirming, nursing staff should not have documented that Resident #20's feed was completed.10 NYCRR 415.12(g)(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. Based on observation, interviews, and record review the facility failed to ensure that drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles on one (Unit 1) of two nursing units. Specifically, during an observation of a medication cart on Unit 1 on 04/02/2026, there were two vials of insulin that did not have resident names on them; two vials of insulin for Resident #93 with no open date; and one insulin vial for Resident #62 that was first opened on 02/26/2026 and was not discarded after 28 days.The findings include:The facility policy titled Medication Storage and Labelling, dated 01/21/2026, documented this facility will store medications safely and securely and in a manner that maintains the integrity of the product in accordance with manufacturer's recommendations, current standards of practice and federal and state regulations. Medication injection pens including insulin pens and cartridges are single patient use only and will be labeled and stored for resident individual use. A multi-dose vial or injection pen that has been opened or accessed (e.g., needle-punctured) should be dated and discarded within 28 days unless the manufacturer specifies a different date for that opened vial or injection pen.During the observation of a medication cart on Unit 1 on 04/02/2026 at 2:00 PM, with Licensed Practical Nurse #2 (unit manager) present, the following observations were made:-There were two opened vials of Novolog insulin (a short acting insulin) dated 03/02/2026 and 03/09/2026 with no resident name.There was one opened vial of Insulin Lispro (a rapid acting insulin) for Resident #93 with no opened date.There was one opened vial of Novolin N insulin Resident #62 dated 02/16/2026, past the expiration date to discard the opened vial of insulin.There was one opened vial of Lantus (a long-acting insulin) insulin for Resident #93 with no opened date.During an interview on 04/02/2026 at 2:05 PM, Licensed Practical Nurse #2 (the unit manager), stated all of the undated and unlabeled insulin vials have to be discarded. Licensed Practical Nurse #2 stated all insulin vials should have a resident name and the date when the vials were opened, and the expired vials should be discarded after 28 days.During an interview on 04/03/2026 at 8:20 AM, Licensed Practical Nurse #3 (medication nurse for the medication cart observed on 04/02/2026) stated they were aware that the insulin vials are supposed to have resident labels on them with the opened dates and should be discarded after 28 days from opening. The insulin vials are sent to us from the pharmacy with the resident label. Over time the resident labels may fall off. There were also new insulins in the cart to replace the expired insulins, but no one discarded the old insulins. Licensed Practical Nurse #3 stated they did not know why they did not discard and/or properly label or date the insulin vials that were in the cart on 04/02/2026.During an interview on 04/03/2026 at 8:36 AM, the Assistant Director of Nursing Services (who is also the nurse educator and Infection Preventionist) stated expired medications should not be in the medication cart. The nurses are supposed to put a date on the insulin vial when they first open the vial, and the resident name must be on the vial. The multidose insulin vials are dedicated to one resident and not used for multiple residents.During an interview on 04/03/2026 at 8:50 AM, the Director of Nursing Services stated if a nurse sees an insulin vial that is undated, or does not have a resident label on it, or is expired, the nurse has to get the vial out of the cart; the nurse must call the pharmacy or speak to me about getting new insulin; the nurses know insulin has to be dated and has to have a resident name on the vial and expires after 28 days. We do not use one vial of insulin for multiple residents.10 NYCRR 415.18(d)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335044	A. Building B. Wing	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Far Rockaway Center for Rehabilitation and Nursing	13 11 Virginia Street Far Rockaway, NY 11691

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interviews, and record review, the facility failed to ensure it maintained an infection prevention and control program designed to help prevent the development of communicable diseases and infections for 1) one (Resident #85) of four residents observed during medication administration; and 2) one of two nursing units observed during the medication storage task. Specifically, 1) during the medication pass observation for Resident #85, Licensed Practical Nurse #1 handled two tablets of Sennosides (a laxative for constipation) with their bare hands after popping the tablets out of the blister pack. The nurse proceeded to administer the tablets to the resident; and 2) during the review of a medication cart on Unit 2, Licensed Practical Nurse #4 stated and demonstrated they cleaned the blood glucose glucometer (a portable, handheld device used to measure current blood sugar levels) with an alcohol prep pad rather than a germicidal wipe that is effective against bloodborne pathogens. The nurse did not have germicidal wipes in their cart.The findings include:The facility policy titled Medication Administration, dated 12/2019, documented staff shall follow established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) when these apply to the administration of medications.The facility policy titled Blood Glucose Testing/Meter/Device, dated 02/01/2024, documented the facility will follow current standards of practice when performing blood glucose testing utilizing a blood glucose meter/device. Clean and disinfect the meter/device before and after each resident use and as needed. Use disinfectant wipe (product based on manufacturer recommendations and risks of pathogen exposure). Remove disinfectant wipe from the container and note the contact/dwell time on the disinfectant container (for example, 1 - 5 minutes). Follow manufacture instructions for cleaning and disinfection. If instructions are not available, follow these guidelines: Clean the outside of the meter/device with the disinfectant wipe, covering all surfaces of the meter/device. After wiping the meter/device, set it on a clean, dry surface and allow the meter/device to stay wet for the period of time recommended on the disinfectant wipe container label (for example, kill time, contact/dwell time).1). Resident #85 was admitted with diagnoses including diabetes mellitus, cerebrovascular accident, and seizure disorder. The 02/09/2026 Annual Minimum Data Set assessment documented a Brief Interview for Mental Status score of 12, indicating the resident had moderate cognitive impairment.During the medication pass observation on 03/31/2026 at 8:20 AM, for Resident #85, Licensed Practical Nurse #1 prepared the following medications as per the physician orders: Amlodipine Besylate tablet 10 milligrams, give one tablet by mouth one time a day for hypertension.Aspirin tablet chewable 81 milligram, give one tablet by mouth one time a day for cerebrovascular accident.Ferrous sulfate tablet 325 milligrams, give one tablet by mouth one time a day for supplementKeppra tablet 500 milligrams, give one tablet by mouth two times a day for seizures.Lamotrigine tablets 25 milligrams, give three tablets by mouth one time a day for seizures.Metformin tablet 500 milligram, give one tablet by mouth two times a day for diabetes mellitus.Sennosides tablet 8.6 milligrams, give two tablets by mouth two times a day for constipation.Licensed Practical Nurse #1 poured the chewable aspirin tablet from the aspirin bottle into a souffle cup and administered that tablet to the resident individually. Licensed Practical Nurse #1 then popped the ferrous sulfate, Keppra, lamotrigine, and metformin tablets all together into a souffle cup directly from their respective blister packs without touching the medications. Licensed Practical Nurse #1 then popped the sennosides tablets from the blister pack directly into their own bare hand. The surveyor pointed out to the nurse that they were holding the sennosides tablet in their hand; the nurse acknowledged that they should not touch the medications with bare hands and then proceeded to add the sennosides tablets to the cup of already prepared oral medications and then administered all the oral tablets to the resident.Review of Licensed Practical Nurse #1's Medication Pass Competency dated 03/19/2026 revealed no criteria regarding handling medications with bare hands.During an interview on 04/01/2026 at 11:00 AM, the Infection Preventionist (who is also the (continued on next page)

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	335044	A. Building B. Wing	04/03/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assistant Director of Nursing and the Nurse Educator) stated handling the medications with bare hands is an infection control concern. The nurse should have discarded all the medications when they added the sennosides to the cup of oral medications.During an interview on 04/02/2026 at 12:35 PM, the Director of Nursing Services stated nurses cannot touch the medications with their bare hands. If they do, they have to discard the medication. 2). During a medication cart inspection on Unit 2 on 04/02/2026 at 1:45 PM, Licensed Practical Nurse #4 stated they used an alcohol prep pad to clean the glucometer and demonstrated the process by opening an alcohol prep pad package and wiping the glucometer with the pad. Licensed Practical Nurse #4 stated they did not know anything about using the germicidal wipes to clean the glucometers and do not carry the germicidal wipes in the cart. Licensed Practical Nurse #4 stated that today they had used the glucometer to check the blood sugars for Resident #13, Resident #70, Resident #55, and Resident #84 and had cleaned the glucometer machine after each use with the alcohol prep pads. During an interview on 04/02/2026 at 1:50 PM, Licensed Practical Nurse #5 (unit manager) stated the medication nurses should be using the germicidal wipes to clean the glucometers. Licensed Practical Nurse #5 then brought a container of germicidal wipes from the nursing station and placed the container on the medication cart. During an interview on 04/03/2026 at 8:36 AM, the Infection Preventionist (who is also the Assistant Director of Nursing and the Nurse Educator) stated the nurses are supposed to use a bleach germicidal product to clean the glucometer after checking a resident's blood sugar. The nurses should not use alcohol prep pads to clean the glucometers because alcohol is not sufficient at killing bloodborne pathogens. During an interview on 04/03/2026 at 8:50 AM, the Director of Nursing Services stated the nurses should know we do not clean the glucometer with an alcohol prep pad; the nurses are supposed to clean the glucometers with the germicidal bleach wipes. 10 NYCRR 415.19(a)(1-3)