STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335156	A. Building B. Wing	08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Shore Rehabilitation and Nursing Center	275 W Merrick Road Freeport, NY 11520

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, record review, and staff interviews, during the Recertification Survey initiated on 08/11/2025 and completed on 08/15/2025, the facility did not maintain an effective pest control program. This was identified during the kitchen task. Specifically, the exit door from the kitchen, which is used to remove refuse and leads to the parking lot and garbage disposal bins, had an approximate half-inch gap at the bottom of the door.This is a repeat citation.The finding is:The undated facility policy titled Pest Control documented to maintenance of an effective pest control system. The facility maintains an ongoing pest control program to ensure that the building is kept free of insects and rodents.On 08/11/2025 at 10:15 AM, during the initial kitchen tour conducted with the Food Service Director (Staff #7), the kitchen exit door leading to the parking lot and garbage disposal bins was observed to have an approximate half-inch gap at the bottom of the door.During an interview on 08/11/2025 at 10:15 AM, the Food Service Director stated they were unaware of the gap at the kitchen exit door. During an interview on 08/12/2025 at 2:32 PM, the Director of Environmental Services (Staff #6) stated the facility was cited for the same issue during the previous survey back in 2024, and the issue was addressed by installing a door sweep. The Director of Environmental Services stated they observed the sweep in place last week but believed it may have been dislodged by delivery staff. The Director of Environmental Services stated they found the door sweep on the floor near the area on 08/11/2025 and reinstalled it. The Director of Environmental Services stated that the door sweep served to deter both water intrusion and pests.During an interview on 08/12/2025 at 3:18 PM, the Administrator was interviewed and stated the door was immediately fixed following the previous survey and that a door sweep was installed to prevent water and pest entry. The Administrator stated they believed a food delivery staff knocked the door sweep loose and that it was later found under a nearby counter.10 NYCRR 415.29 (J)(5)

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews during the Recertification Survey initiated on 08/11/2025 and completed on 08/15/2025, the facility did not ensure that Physician Responses (actions) documented on Monthly Medication Regimen Reviews were carried out to address irregularities identified by the Pharmacist. This was identified for three (3) (Resident #1, #32, and #12) of five (5) residents reviewed for Unnecessary Medications. Specifically, recommendations were provided by the Pharmacy consultant on the Medication Regimen Review Form for Resident #1, Resident #32, and Resident #12; however, the recommendations were not implemented, and there was no documented evidence in the residents' medical records that the identified irregularities were reviewed and what, if any, actions were taken to address the irregularities. The findings are: The facility's undated policy titled, Pharmacy Drug Regimen Reviews, documented the Consultant Pharmacist shall identify, document, and report possible medication irregularities for review and action by the Attending (Primary) Physician when appropriate. The Attending (Primary) Physician or licensed designee shall respond to the Drug Regimen Review within seven (7) days of receipt. The Primary Care Physician must document on the Drug Regimen Review Sheet if they agree or disagree with the recommendation and provide a brief clinical rationale if no change is to be made. The Primary Care Physician is responsible for completing the Drug Regimen Review Sheet to ensure compliance with the acceptable time frame for completion. The Medical Director will review the Drug Regimen Review Sheets on a regular basis and ensure the Physicians are compliant with documentation. 1) Resident #1 was admitted with diagnoses including Respiratory Failure, Cerebrovascular Accident, and Benign Prostatic Hyperplasia (prostate gland enlargement, potentially causing urinary problems). The 07/29/2025 Quarterly Minimum Data Set assessment documented a Brief Interview for Mental Status score of 1, indicating the resident had severe cognitive impairment. The physician's order, originally ordered on 04/23/2025 and most recently renewed on 08/05/2025, documented Flomax Oral Capsule 0.4 milligram (Tamsulosin HCl), give one (1) capsule via Gastrostomy Tube (feeding tube into stomach) in the evening for Benign Prostatic Hyperplasia. Review of the July 2025 and August 2025 Medication Administration Records revealed the resident received Flomax every day in July and in August 2025, until 08/06/2025. The medication was discontinued on 08/15/2025. A Pharmacy Monthly Medication Regimen Review dated 06/29/2025 documented Resident #1 has an order for Flomax via Gastrostomy-tube. This capsule should not be opened. Consider changing to Rapaflo. The response dated 07/01/2025 was documented by the Director of Nursing Services: Physician consulted. There was no documented evidence in the resident's medical record that the identified irregularity had been reviewed by the Physician, and what, if any, actions had been taken to address it. A Pharmacy Monthly Medication Regimen Review dated 08/08/2025 documented Resident has an order for Flomax via G-tube. This capsule should not be opened. Consider changing to Rapaflo. The response dated 08/11/2025 was documented by the Director of Nursing Services: continue with Rapaflo after delivery from pharmacy. There was no documented evidence in the resident's medical record that the identified irregularity had been reviewed by the Physician, and what, if any, actions (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	had been taken to address it. During an interview on 08/13/2025 at 10:30 AM with the facility's pharmacy medication provider, Pharmacist #1 stated we have not received an order from the facility for Rapaflo; the last order for Flomax was 08/05/2025; Rapaflo was never ordered. As per the Flomax manufacturer's Highlights of Prescribing Information dated January 2016, the Flomax capsule should be swallowed whole and not opened or crushed due to the risk of increased side effects, including Hypotension (low blood pressure). During an interview on 08/13/2025 at 10:35 AM, the Director of Nursing Services stated that they signed the Medication Regimen Reviews and not the Physician. The Director of Nursing Services acknowledged that Rapaflo had not been ordered even though the responses on the Medication Regimen Reviews indicate that Flomax was supposed to be changed to Rapaflo. A physician's order dated 08/13/2025 documented Rapaflo Oral Capsule 4 milligram (Silodosin), give 1 capsule via G-Tube in the evening for Benign Prostatic Hyperplasia. 2) Resident #32 was admitted with diagnoses including Iron Deficiency Anemia (a condition in which the body does not have enough iron to produce healthy red blood cells). A Quarterly Minimum Data Set assessment dated [DATE] documented that a Brief Interview for Mental Status was not conducted because the resident was rarely or never understood, and the resident had severely impaired cognitive skills for daily decision making. The Minimum Data Set Assessment documented the resident had a feeding tube during the assessment period. A Comprehensive Care Plan titled Anemia last revised 02/19/2025, documented interventions including encouraging intake of food high in iron and Vitamin C, monitoring and reporting signs and symptoms of Anemia, and giving medications as ordered. A Physician's order dated 06/18/2025 documented to administer Ferrous Sulfate 325 milligram Tablet, one (1) tablet via a percutaneous endoscopic gastrostomy tube (a type of feeding tube) one (1) time a day for Anemia. The Medication Regimen Review dated 06/20/2025 documented the pharmacy recommendations, including to consider changing the Ferrous sulfate tablet to liquid form via a feeding tube. A response to the Medication Regimen Review dated 06/21/2025 documented that the Physician agreed to the recommendation. The response was signed by the Director of Nursing Services. There was no signature documented from the attending physician or the Medical Director on the Medication Regimen Review. The Medication Regimen Review dated 07/29/2025 documented pharmacy recommendations, including to consider changing Ferrous sulfate tablet to a liquid form for administration via a feeding tube. A response dated 07/31/2025 documented that the Physician agreed with the recommendation to change the Ferrous sulfate tablet to liquid form. The Medication Regimen Review form was signed by the Director of Nursing Services, and there were no signatures documented on the form by the attending physician or the Medical Director. A review of the Medication Administration Record from 06/2025 to 08/2025 revealed Resident #32 received Ferrous Sulfate 325 milligrams via a percutaneous endoscopic gastrostomy tube in tablet (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	form. There was no documented evidence that the Physician's Order for Ferrous Sulfate for Resident #32 was changed from tablet form to liquid form following the pharmacy recommendations on 06/20/2025 and 07/29/2025. 3) Resident #12 has diagnoses that include Crohn's Disease (a type of inflammatory bowel disease that causes swelling and irritation of the tissues, called inflammation, in the digestive tract) and Anemia (a problem of not having enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues). The admission Minimum Data Set assessment dated 05.15.2025 documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognitive skills for daily decision making. The Physician's Order dated 05/23/2025 and last renewed on 07/22/2025 documented for the resident to receive Retacrit Injection solution 10000 units/milliliter (Epoetin Alfa-epbx) - inject 10000 units subcutaneously one time a day every Monday, Wednesday, and Friday for Anemia The Medication Regimen Review dated 07/28/2025 documented: Resident on Retacrit for Anemia. Consider adding Ferrous Sulfate. The response was documented by the Director of Nursing Services on 07/30/2025: Agree, Physician (MD) consulted. The Monthly Medication Regimen Review was not signed by the resident's Primary Care Physician. Review of the resident's Electronic Medical Record on 08/14/2025 at 11:30 AM revealed the resident was not receiving and had never received Ferrous Sulfate. During an interview on 08/14/2025 at 01:47 PM, the Director of Nursing Services stated they review the Medication Regimen Reviews for the facility and notify the attending physicians through electronic correspondence or verbal communication. The Director of Nursing Services stated they felt this process would be much faster than leaving the forms in the Physician's mailbox for the Physicians to review and document on the forms directly. The Director of Nursing Services stated the completed Medication Regimen Review forms were placed in the Medical Director's mailbox for the Medical Director to review and sign. They were not sure why the Medical Director did not sign the Medication Regimen Review forms for Resident #1, Resident #32, and Resident #12. The Director of Nursing Services stated they did not know the Physicians were responsible for documenting a response and signing the Medication Regimen Review form, as documented in the facility policy. The Director of Nursing Services stated they felt that they had to document responses on the form themselves in order to complete the review within three (3) days. The Director of Nursing Services stated the recommendations should have been put in place for Resident #1, Resident #32, and Resident #12, and the Physicians should be responsible for ensuring the recommendations were followed and orders were put in place accordingly. During an interview on 08/14/2025 at 02:25 PM, the Primary Physician stated they could not recall the Director of Nursing Services had notified them of the recommendations made by the Pharmacy Consultant for Resident #1, Resident #32, and Resident #12. The Primary Physician stated they were not aware they were supposed to document a response and sign on the Medication Regiment Review form. During an interview on 08/15/2025 at 02:46 PM, the Medical Director stated they expected the attending physicians to review the Medication Regimen Review forms for each resident, and even (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	though the Director of Nursing Services may document a response on the form, they expect the physicians to review and sign off with their responses on the form. The Medical Director stated that recommendations that the physician agreed upon should be implemented within three (3) to seven (7) days. During an interview on 08/15/2025 at 03:23 PM, the Medical Director stated it was the facility policy that the Physicians sign their responses on the Medication Regimen Review forms. The Medical Director stated that they expected the attending Physicians to be aware of the facility's policy regarding Medication Regimen Reviews. 10 NYCRR 415.18(c)(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 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 the Recertification Survey initiated on 08/11/2025 and completed on 08/15/2025, the facility did not ensure that it developed and implemented a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet each resident's medical, nursing, and mental and psychosocial needs. This was identified for one (1) (Resident #14) of three (3) residents reviewed for Skin Conditions and one (1) (Resident #32) of five (5) residents reviewed for Unnecessary Medications. Specifically, 1) Resident #14 had a diagnosis of Methicillin-Resistant Staphylococcus Aureus (a type of bacteria that is resistant to antibiotics) infection in the chest wounds. There was no care plan developed for the wound infection and the contact precautions. 2) Resident #32 was receiving treatment for their heart conditions, including an anticoagulant therapy and treatment for hypotension (low blood pressure). There was no documented evidence of a comprehensive care plan regarding the resident's cardiovascular status.The findings are: The facility's policy titled Comprehensive Care Plan, dated 03/2016, documented the interdisciplinary team will assess the resident's condition, develop a working comprehensive care plan for each resident, and establish realistic, individualized care goals utilizing the resident's active and potential problems and current standard of professional practice. Interdisciplinary team members will document the resident's problem-prone areas identified by the comprehensive assessment, design, and document specific interventions/approaches on the comprehensive care plan. The Interdisciplinary Team Coordinator will ensure that a resident's 21-day comprehensive care plan is complete, including, but not limited to: identified resident care problems or needs and interventions and/or approaches to be used. 1) Resident #14 was re-admitted with diagnoses including Methicillin Resistant Staphylococcus Aureus Infection, Disorder of the Skin and Subcutaneous Tissue, and Cellulitis (skin infection). The 05/26/2025 Entry Minimum Data Set assessment documented a Brief Interview for Mental Status score of eight (8), indicating the resident had moderate cognitive impairment. Resident #14 had a diagnosis of Septicemia (life-threatening infection in the blood). The Minimum Data Set did not document the presence of non-pressure-related ulcers, wounds, or skin problems. A current Physician's order dated 07/02/2025 documented contact precautions for Methicillin Resistant Staphylococcus Aureus Infection. The current Physician's order dated 07/24/2025 documented: cleanse the right and left chest wound with normal saline, apply collagen powder to the wound base, then pack the wound with Calcium Alginate (a highly absorbent wound dressing), and cover with Silicone Super absorbent three (3) times a week and as needed for Wound Care. A review of the Comprehensive Care plans revealed there was no care plan developed to indicate the resident had an infection in the chest wounds and was on contact precautions. During an observation and interview on 08/13/2025 at 11:09 AM, Resident #14 was lying in their bed. Resident #14 stated they had just received treatment for their wounds on the chest. A Contact Precaution sign was posted in front of Resident #14's room. Two (2) Certified Nursing Aides were observed donning (putting on) gowns and gloves prior to entry in the room with a Hoyer lift. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/14/2025 at 2:50 PM, Registered Nurse #1 stated the resident was readmitted in May 2025 with a bilateral chest wound and was placed on Contact Precaution due to Methicillin-Resistant Staphylococcus Aureus Infection in the wound. Registered Nurse # 1 stated that the admission nurse usually initiated all the care plans; however, other Registered Nurses were also responsible for ensuring care plans were developed and implemented to reflect the resident's needs. Registered Nurse # 1 stated that they were not aware that Resident #14 did not have a care plan for their Methicillin-Resistant Staphylococcus Aureus Infection and contact precautions. Registered Nurse #1 stated that the care plans should have been developed. During an interview on 08/14/2025 at 2:28 PM, the Director of Nursing Services, who is the facility's Infection Preventionist, stated that only a Registered Nurse can initiate a care plan, and they expect the Registered Nurse to develop a care plan for Resident #14's Methicillin-Resistant Staphylococcus Aureus Infection and contact precautions. 2) Resident #32 was admitted with diagnoses including Essential Hypertension and Idiopathic Hypotension (a type of low blood pressure that happens when standing up, with the exact cause unknown). The Quarterly Minimum Data Set assessment dated [DATE] did not document a Brief Interview for Mental Status score because the resident had severely impaired cognitive skills for daily decision making and was rarely or never understood. A Physician's order dated 06/18/2025 documented to administer Midodrine (a medication used to treat low blood pressure) 5 milligram Tablet, two (2) tablets via a percutaneous endoscopic gastronomy tube (a type of feeding tube) every eight (8) hours as needed for Systolic blood pressure (the top number in a blood pressure reading representing the pressure in the arteries when the heart muscle contracts) reading under 120 millimeters of mercury. A Physician's Order dated 06/18/2025 documented to administer Metoprolol Tartrate (a type of blood pressure medication) 25 milligram tablet, give half a tablet via a percutaneous endoscopic gastrostomy tube every 12 hours for Hypertension. A Physician's Order dated 06/18/2025 documented to administer Enoxaparin Sodium (a type of anticoagulant medication) Solution Prefilled Syringe 40 milligrams per 0.4 milliliters, inject 40 milligrams subcutaneously (layer of fatty tissue beneath the skin) one time a day for blood clot prevention. A Physician's Order dated 06/23/2025 documented to monitor orthostatic blood pressure sitting and lying weekly. A Cardiology Consult Note dated 07/02/2025 documented Resident #32 was seen for a follow-up for hypotension and monitoring. Recommendations included to continue monitoring the resident's blood pressure daily and continuing with the current dose of Metoprolol, Midodrine treatment, and Enoxaparin for Deep Vein Thrombosis (blood clot in the deep veins) prevention and bleeding precautions. The resident was clinically stable. There was no documented evidence that a comprehensive care plan was developed for Resident #32's Cardiovascular status and use of anticoagulant therapy. During an interview on 08/14/2025 at 11:45 AM, Registered Nurse #4, the unit nursing supervisor, stated that typically a care plan is initiated by the nursing supervisors upon admission, and the (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nursing supervisors may also update care plans as needed. Registered Nurse #4 stated a comprehensive care plan should be developed for all diagnoses and health concerns for each resident. Registered Nurse #4 stated they did not know why a care plan was not developed for Resident #32's Cardiovascular status and anticoagulation therapy use. During an interview on 08/14/2025 at 01:47 PM, the Director of Nursing Services stated a comprehensive care plan was meant to outline a resident's plan of care for a specific condition/concern with measurable goals and interventions for the nursing staff to follow and evaluate the resident's condition. The Director of Nursing Services stated a comprehensive care plan should have been developed for Resident #32 to reflect the resident's Cardiovascular status and anticoagulation therapy. 10 NYCRR 415.11(c)(1)

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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 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. Based on observation, record review, and interviews during the Recertification Survey initiated on 08/11/2025 and completed on 08/15/2025, the facility did not ensure services provided as outlined in the comprehensive care plan met professional standards of quality. This was identified for one (1) (Resident #75) of four (4) residents reviewed for Medication Administration. Specifically, during the medication administration observation for Resident #75 on 08/12/2025, Registered Nurse #6 did not follow the five rights (right person, right time, right medication, right route, right dosage) of medication administration and poured liquid Keppra (a medication for seizures) from another resident's medication bottle without checking the label. Additionally, Registered Nurse #6 did not check the placement of the gastrostomy tube before administering the medications to Resident #75.Cross Reference F755-Pharmacy Services/Procedure/Pharmacist/RecordsThe finding is:The facility's policy, titled Administration of Drugs, reviewed 12/07/2007, documented to ensure that all residents are given the proper medication in the proper dosage, via the proper route, and at the proper time. The medication name, dosage, and dosage interval shall be read from the medication administration records. The label on each medication container shall be read three times when taking the medication container from the shelf or drawer, before pouring the medication, and when putting the medication back onto the shelf or into the drawer.The facility's policy titled Medication Administration via Feeding Tube, revised 06/2023, documented disconnect tube feeding (if in progress) and cap the tube; assess resident's abdomen; check tube placement and patency by either aspirating (pulling up with a syringe) gastric contents or auscultating (listening with a stethoscope as air is pushed into the stomach with a syringe) for instilled air.Resident #75 was admitted with diagnoses including Cerebrovascular Accident, Seizure Disorder, and Gastrostomy (feeding tube to stomach) Status. The 04/19/2025 Quarterly Minimum Data Set assessment documented no Brief Interview for Mental Status score, as the resident had severely impaired cognitive skills for daily decision making.The current physician's order documented to check patency of tube feed prior to any medication pass every shift, related to Gastrostomy Status.The current physician's order documented to start enteral feed (tube feeding) in the evening, Type Jevity 1.5, Total Formula Volume 1,200 cubic centimeters per day, Flow Rate 75 cubic centimeters/hour, Start time: 6:00 PM, Check for residual prior to initiation of feeding.During the medication administration observation on 08/12/2025 at 08:20 AM, Registered Nurse #6 prepared the following medications for Resident #75:Vitamin C 500 milligram tablet (supplement).Zinc 50 milligram tablet (supplement).Vitamin B-6 50 milligram tablet (supplement).Multivitamin tablet (supplement).Probiotic capsule (helps maintain a healthy balance of gut bacteria).Furosemide 20 milligram tablet (diuretic).Glycopyrrolate 1 milligram tablet (reduces stomach acid).Keppra Oral Solution 10 milliliters (100 milligrams per milliliter) (for convulsions).Registered Nurse #6 poured the Keppra oral solution for Resident #75 into a souffle cup without reading the bottle label. Although the medication was the same, the Keppra bottle had another resident's name on the label instead of Resident #75. The surveyor asked to see the Keppra medication bottle, which was when Registered Nurse #6 read the bottle label and realized the medication bottle was not for Resident #75. Registered Nurse #6 was unsure of what to do with the medication that was already poured and stated, I guess I will just use it, and later decided to discard the medication and re-poured the medication from the appropriate bottle. After Registered Nurse #6 completed preparing the medications (crushing the tablets because of the gastrostomy tube), the nurse applied all the appropriate personal protective equipment and then entered the resident's room. The nurse disconnected the tube feeding, flushed the tube, but did not check for the placement of the tube.During an interview immediately after the observation, Registered Nurse #6 stated they did not check for the placement of the gastrostomy tube before administering the medications via the tube, and should have.During an interview on 08/14/2025 at 10:10 AM, the Assistant Director of Nursing/Educator stated that the nurses are supposed to check for the placement of the gastrostomy (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tube by aspirating the gastric contents or by auscultation (injecting air into the gastrostomy tube while listening with a stethoscope over the stomach for a whooshing sound) before administering the medications. The Assistant Director of Nursing/Educator stated nurses must check the medication labels before dispensing the medication to ensure the right person, right time, right medication, right route, and right dosage.During an interview on 08/15/2025 at 8:15 AM, the Director of Nursing Services stated nurses are expected to follow the five rights of medication administration. If the nurse noticed they poured the medication from the wrong resident's bottle, they should have wasted the medication and started over. The Director of Nursing Services further stated the facility policy requires nurses must check for gastrostomy tube placement before administering medications through a gastrostomy tube.10 NYCRR 415.11(c)(3)(i)

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observations, record review, and interviews during the Recertification Survey and Abbreviated Survey (2572082) initiated on 08/11/2025 and completed on 08/15/2025, the facility did not ensure that each resident who is unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This was identified for one (Resident #24) of two residents reviewed for Activities of Daily Living. Specifically, upon several observations, Resident #24 was not clean-shaven, and their hair was mussed. Resident #24's plan of care indicated the resident was to receive scheduled showers at least two times per week. Review of the resident's record indicated Resident #24 received only one shower from 07/23/2025 to 08/12/2025.The finding is: The facility's undated policy titled Certified Nursing Assistant Plan of Care and Kardex documented that each resident will be provided with proper and safe basic nursing care by the Certified Nursing Assistant. The primary care nurse should update the Kardex (care instructions provided to the Certified Nursing Assistants) as needed for changes in activities of daily living. The Certified Nursing Assistant will bring to the attention of the primary care nurse or supervisor any area of the plan of care that is not completed or does not match the resident's current status.Resident #24 was admitted with diagnoses including Traumatic Brain Dysfunction, Aphasia (a disorder that causes difficulty speaking and understanding), and Anxiety Disorder. The 04/24/2025 admission Minimum Data Set assessment documented no Brief Interview for Mental Status score as the resident had severely impaired cognitive skills for daily decision making. The Minimum Data Set documented that it was very important to choose between a tub bath, shower, bed bath, or sponge bath and that the resident was dependent on staff for personal hygiene and bathing. The 07/19/2025 Quarterly Minimum Data Set assessment documented a Brief Interview for Mental Status score of three (3), indicating the resident had severe cognitive impairment, unclear speech, and sometimes understands and sometimes understood.During an observation on 08/11/2025 at 10:10 AM, Registered Nurse Supervisor #7 was assisting Resident #24 into a temporary bed in another room while the bed in their room was being repaired. The resident's speech was unclear. The resident was unshaven, and their hair was mussed.During an observation on 08/12/2025 at 8:05 AM, Resident #24 was in bed. Certified Nursing Assistant #2 was in the room preparing to provide morning care to the resident. The resident was unshaven.During an observation on 08/12/2025 at 9:15 AM, Resident #24 was in the hallway. The resident was unshaven. The surveyor asked the resident if they would like to be shaved, and the resident appeared to state yes by shaking their head up and down. During an interview on 08/12/2025 at 8:10 AM, Certified Nursing Assistant #2 stated they did not shave the resident because the resident was combative during care this morning.Review of the Kardex as of 08/12/2025 documented that the resident's bathing schedule was on Tuesday and Friday on the 7:00 AM-3:00 PM shift. The resident required the extensive assistance of two staff members. There were no behavioral concerns documented in the Kardex.Review of the Certified Nursing Assistant accountability record from 07/23/2025 to 08/12/2025 revealed the resident received a shower on 7/26/2025 (Saturday); all other documentation reveals the resident received bed baths during that period.During an interview on 08/12/2025 at 1:43 PM, Certified Nursing Assistant #2 stated today was the first time they were working with Resident #24. Certified Nursing Assistant #2 stated the Kardex documented that the resident was due for a shower today (Tuesday), but they gave a bed bath because the resident was physically aggressive. Certified Nursing Assistant #2 stated that the bathing schedule on the Kardex meant showers. Certified Nursing Assistant #2 stated they notified the nurse (Registered Nurse Supervisor #5) and documented on the accountability record that they provided a bed bath to the resident.During an interview on 08/12/2025 at 2:40 PM, Registered Nurse Supervisor #5 stated the Certified Nursing Assistant told them that the resident (#24) did not get a shower today because the resident was agitated. Registered Nurse Supervisor #5 stated the resident should be getting showers twice a week and had no explanation as to why the resident was not (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	getting showers. A nursing progress note, written by Registered Nurse Supervisor #5, dated 08/12/2025 at 3:18 PM, documented resident (#24) was alert and confused. The resident was combative this morning and, as a result, was not shaved or showered; however, the resident was given a bed bath. As needed Xanax (anti-anxiety medication) 0.5 milligram was administered with much relief.Review of progress notes from 07/26/2025 to 08/12/2025 revealed no documentation that the resident did not receive a shower due to behavioral issues.Review of the electronic medical record revealed that there was no comprehensive care plan for the Activities of Daily Living initiated until 08/13/2025.During an interview on 08/13/2025 at 2:25 PM, the Assistant Director of Nursing/Nurse Educator stated they reviewed Resident #24's electronic medical record and determined there was no documentation that the resident received showers as per their plan of care. The Assistant Director of Nursing/Nurse Educator stated that the resident has unpredictable, erratic behaviors, including grabbing and reaching for things, and that is probably why they did not get showers.A Comprehensive Care Plan, effective 06/10/2025, titled Behaviors, had an addition on 08/13/2025 by the Director of Nursing Services, documenting the resident has a behavior problem related to agitation and attempting to stand, combative and impulsive behavior during care, causing potential for a safety issue during shower.A Comprehensive Care Plan initiated 8/13/2025 initiated by the Director of Nursing Services titled Resident assessed for Activities of Daily Living status upon admission documented Certified Nursing Assistants will document support provided and self-performance for all Activities of Daily Living, Encourage resident to participate in Activities of Daily Living as per ability and personal preferences; Provide shower/bed bath, based upon resident's preference/ability, twice per week and as needed.During an interview on 08/14/2025 at 9:34 AM, Physical Therapist Rehabilitation Department Director #1 stated that due to behaviors, Resident #24 was dependent on two staff members for showers and requires two staff members to transfer to and from the shower chair.On 08/14/2025 at 10:48 AM, Resident #24 was observed being brought back to their bedside in a shower chair by Certified Nursing Assistant #2 and Concierge #1 after receiving a shower.On 08/14/2025 at 11:30 AM, Resident #24 was observed in the day room. The resident was groomed, showered, and shaved.During an interview on 08/15/2025 at 8:15 AM, the Director of Nursing Services stated the resident should have received showers twice a week. If the resident was combative during care, then it should have been documented, and the staff should have reviewed the current interventions and put new interventions in place to provide needed care to the resident.10 NYCRR 415.12(a)(3)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews during the recertification Survey initiated on 08/11/2025 and completed on 08/15/2025, the facility did not ensure each resident received treatment and care in accordance with professional standards. Specifically, Resident #32 had an active physician's order for Midodrine (a medication used to treat low blood pressure) every eight (8) hours as needed when the resident's systolic blood pressure (the top number in a blood pressure reading representing the pressure in the arteries when the heart muscle contracts) was below 120 millimeters of mercury. Review of Resident #32's Medication Administration Record for July and August 2025 revealed that in 08/2025 the resident did not receive the medication as ordered for 16 out of 16 opportunities from 08/01/2025 to 08/13/2025; and in July 2025, the resident did not receive Midodrine for 26 of 29 opportunities. There were nine times when the blood pressure was not documented on the Medication Administration Record for July 2025. Additionally, there was no documented evidence on the Medication Administration Record that the resident's blood pressure was monitored every eight hours for the nurses to determine the need to administer Midodrine as per the physician's order.The finding is:The facility policy titled Administration of Drugs, last reviewed on 12/07/2007, documented all residents should be given the proper medication in the proper dosage via the proper route and at the proper time. Medications given on an as-needed basis shall be recorded on the medication administration record with an explanation entered. If a dose of a regular interval medication is withheld, the nurse shall record an explanatory nurse's note.Resident #32 was admitted with diagnoses including Essential Hypertension and Idiopathic Hypotension (a type of low blood pressure that happens when standing up, with the exact cause unknown). The Quarterly Minimum Assessment Data Set assessment dated [DATE] did not document a Brief Interview for Mental Status because the resident had severely impaired cognitive skills for daily decision making and was rarely or never understood.There was no documented evidence of a comprehensive care plan in the medical record relating to the resident's cardiovascular status.A Physician's Order dated 06/18/2025 documented to administer Metoprolol Tartrate (a type of blood pressure medication) 25 milligram tablet, give half a tablet via a percutaneous endoscopic gastrostomy tube (a type of feeding tube) every 12 hours for Hypertension.A Physician's order dated 06/18/2025 documented to administer Midodrine 5 milligram Tablet, two (2) tablets via a percutaneous endoscopic gastronomy tube (a type of feeding tube) every eight (8) hours as needed for a Systolic blood pressure reading under one hundred and twenty (120) millimeters of mercury.A review of Resident #32's Medication Administration Record for 08/2025 revealed the resident did not receive the medication as ordered for 16 out of 16 opportunities from 08/01/2025 to 08/13/2025. For July, the resident did not receive Midodrine for 26 of 29 opportunities. There were nine times when the blood pressure was not documented on the Medication Administration Record for July 2025.There was no documented evidence on the Medication Administration Record that the resident's blood pressure was monitored every eight hours for the nurses to determine the need to administer Midodrine as per the physician's order.During an interview on 08/14/2025 at 11:14 AM, Licensed Practical Nurse #1, the medication nurse, stated they were the regularly assigned nurse on the unit and were very familiar with Resident #32. Licensed Practical Nurse #1 stated the resident had an order for Midodrine as needed. The resident's blood pressure is checked before administering the blood pressure medications. Licensed Practical Nurse #1 stated Resident #32's systolic blood pressure on 08/12/2025 during the 7:00 AM-3:00 PM shift was 112 millimeters of mercury. Licensed Practical Nurse #1 stated they did not administer Midodrine because the resident did not have symptoms of lethargy, and the resident was not in any distress. Licensed Practical Nurse #1 stated they typically do not administer Midodrine to the resident because it was not necessary when the resident was asymptomatic and the blood pressure remained stable, despite the parameters on the physician's order.During an interview on 08/14/2025 at 11:36 AM, Registered (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse #4, the nursing supervisor, stated the blood pressure parameters ordered by the physician for Midodrine were higher than what was typically ordered. Registered Nurse #4 stated the order for Midodrine would need to be clarified with the Physician.During an interview on 08/14/2025 at 02:25 PM, Primary Physician #1 stated nursing staff must administer medication as ordered, including following any parameters ordered by the Physician. Primary Physician #1 stated Midodrine should have been administered to Resident #32 if the blood pressure was recorded below 120 millimeters of Mercury.During an interview on 08/15/2025 at 12:53 PM, the Director of Nursing Services stated that nurses should have administered the Midodrine according to the blood pressure parameters as ordered.10 NYCRR 415.12

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews during the Recertification survey initiated on 08/11/2025 and completed on 08/15/2025, the facility did not ensure each resident with a pressure ulcer received the necessary treatment and services, consistent with professional standards of practice, to promote wound healing, prevent infection, and prevent new ulcers from developing. This was identified for two (2) (Resident #16 and Resident #2) of two (2) residents reviewed for pressure ulcers. Specifically, 1) Resident #16 weighed 84.7 pounds and was observed lying in bed with the air mattress weight setting set at 350 pounds. 2) Resident #2 was observed with an air mattress with a low-pressure warning light illuminated on 08/11/2025, 08/12/2025, and 08/13/2025. When the mattress was replaced, the weight setting on the air mattress was set at 350 pounds. The resident's weight was 115 pounds.The findings are: A facility policy titled Impaired Skin Integrity last revised on 04/2018, documented once a resident is assessed, a plan of care for prevention and/or treatment plans for residents with wounds will be developed. The Physician will be notified, and orders will be obtained to correspond with the nursing assessment. Possible interventions that should be used include pressure relief devices such as heel pads, specialty mattresses, and/or chair cushions. A facility policy titled Air Mattress dated 01/2025 documented to provide an air mattress to residents when warranted. Air mattresses help to evenly distribute the resident's weight, facilitate air circulation, thereby preventing moisture build-up on the skin, and can improve blood circulation, further reducing the risk of developing pressure ulcers. It is the responsibility of the primary care nurse to ensure the mattress reflects the proper setting, dependent on the resident's weight. This setting may be adjusted in order to assist in transfer, to assist in turning and positioning, and to assist while providing care. The Alternating Pressure Low Air Loss Mattress manual documented after proper installation of the air mattress, determine the resident's weight and set the control knob to that weight setting on the control unit of the air mattress. Ensure the control unit is in good condition by checking if the indicators illuminate when the power is first turned on. 1) Resident #16 was admitted with diagnoses including Spondylosis with Radiculopathy (spinal degeneration that leads to nerve root compression), Adult Failure to Thrive, and Chronic Kidney Disease. The Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of three (3), indicating the resident had severe cognitive impairment. The Minimum Data Set assessment documented the resident was at risk for developing pressure ulcers; had two (2) unhealed, Stage three (3) (full-thickness tissue loss) pressure ulcers that were present upon admission; and used a pressure-reducing device for bed. A Comprehensive Care Plan titled Skin Integrity: The Resident has Actual Impairment to Skin Integrity last revised 07/11/2025, documented interventions including the use of an air mattress for pressure reduction, turn and position every two (2) to four (4) hours and as needed, and apply treatment as ordered by the Physician. The current Physician's Order documented an air pressure mattress related to wounds. No further instructions related to the air mattress settings were included in the Physician's order. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Braden Scale assessment dated [DATE] documented a score of 14, indicating the resident had a moderate risk of developing pressure ulcers. Review of the medical record documented the resident weighed 84.7 pounds on 8/6/2025. A Wound Care Consultation Note dated 08/07/2025 documented low air loss mattress per facility protocol, and to verify low air loss mattress inflation and settings. The resident had multiple wounds, including two (2) Stage three (3) pressure ulcers to the sacrum (a triangular bone at the base of the spine) and right ischium (the lower and back portion of the hip bone). During an observation on 08/12/2025 at 9:46 AM, Resident #16 was observed lying in bed on an air mattress with the weight setting set at 350 pounds. During a subsequent observation on 8/13/2025 at 10:29 AM, Resident #16 was observed lying in bed on an air mattress with the weight setting set at 350 pounds. During an interview on 08/13/2025 at 11:15 AM, Certified Nursing Assistant #1, the assigned Certified Nursing Assistant for Resident #16, stated they were responsible for checking if the mattress was deflated or leaking. Certified Nursing Assistant #1 stated they were not responsible for checking the weight setting on the air mattress. During an interview and observation on 08/13/2025 at 11:24 AM, in the presence of Registered Nurse #2, Resident #16 was lying in bed with the air mattress weight setting set at 350 pounds. Resident #16 stated their bed felt hard and uncomfortable. Registered Nurse #2 stated they usually check the air mattress settings for firmness and that the mattress was inflated during rounds and medication administration. Registered Nurse #2 stated they were not sure how the weight setting for the air mattress should be set. During an interview on 08/13/2025 at 11:45 AM, Registered Nurse #3, the nursing supervisor, stated that the unit nurses were responsible for checking the functioning and weight settings on the air mattress. Registered Nurse #3 stated Resident #16 weighed 84.7 pounds, and the air mattress setting should correspond with the resident's actual weight. Registered Nurse #3 stated the air mattress setting of 350 pounds was too high for Resident #16. During an interview on 08/15/2025 at 08:56 AM, the Wound Care Nurse stated it was not appropriate for Resident #16's air mattress to be set at 350 pounds as this did not reflect the resident's actual weight. During an interview on 08/15/2025 at 11:05 PM, the Vascular Surgeon, the Wound Care Consultant for the facility, stated they followed Resident #16 for wound care weekly. The Vascular Surgeon stated they recommended a low air low-air-loss mattress for Resident #16 to prevent wound deterioration and promote wound healing. The air mattress weight setting should be set according to the resident's weight. The air mattress weight setting of 350 pounds was not appropriate for Resident #16, especially when the resident is in bed for an extended period. During an interview on 08/15/2025 at 12:42 PM, the Director of Nursing Services stated the nurses on the unit were responsible for ensuring the air mattresses were set correctly for each resident according to the resident's weight. The Director of Nursing Services stated that the only occasion the mattress should be set at a higher weight setting is during transfers and turning, and repositioning. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The air mattress for Resident #16 should not have been set at 350 pounds and should have accurately reflected the resident's actual weight. 2) Resident #2 was admitted with diagnoses including Diabetes Mellitus, Cerebrovascular Accident, and Anoxic (the brain deprived of oxygen) Brain Damage. The 08/05/2025 admission Minimum Data Set assessment documented no Brief Interview for Mental Status score as the resident had severely impaired cognitive skills for daily decision making; the resident was admitted with one Stage 4 pressure ulcer (full-thickness skin and tissue loss extending into muscle, tendon, or bone); two unstageable pressure ulcers due to coverage with slough/and or eschar (dead tissue), and three Unstageable-Deep Tissue Injury (damage occurs to underlying soft tissues) pressure ulcers. A Comprehensive Care Plan titled, Skin integrity: Resident has the potential for impaired skin integrity related to actual ulcers, impaired mobility, effective 07/31/2025, documented providing pressure relief interventions: elbow pads. The care plan did not include the use of an air mattress. The air mattress manual documented the Low-Pressure Indicator light warns that the air pressure is below a preset or user-defined level. The audible alarm is activated, accompanied by the Low-Pressure indicator, to alert that pressure is low. Press the alarm mute button to mute the audible alarm, and its indicator will flash. Pressure adjust knob: turn the soft/firm knob to set a comfortable pressure level. (This knob also has the weight settings.) The wound care consult note dated 07/31/2025 documented a Stage 4 sacral (triangular bone at lower back) pressure ulcer, 11 centimeters x 5 centimeters x 1.8 centimeters; a Stage 2 (partial thickness skin loss like a blister) left hip pressure ulcer measuring 2 centimeters x 2 centimeters x 0 centimeters; and a Diabetic wound to the left foot. The consult documented using the low air loss mattress as per facility protocol, and the low air loss mattress inflation and settings were verified. A review of the electronic medical record revealed the resident's weight was 115.5 pounds as of 08/06/2025. On 08/11/2025 at 10:25 AM, Resident #2 was observed in bed. The resident had an air mattress with a low-pressure light illuminated. The weight setting on the air mattress was 180 pounds. During an interview and observation on 08/12/2025 at 2:05 PM, Licensed Practical Nurse #2 observed Resident #2's mattress with the low-pressure light still illuminated. At this time, the resident was getting Rehabilitation Therapy while in bed. Licensed Practical Nurse #2 stated the low-pressure light was on because the resident was moving while receiving the therapy. The weight setting was set at 170 pounds. Licensed Practical Nurse #2 stated they will look at the mattress and try to figure out if there was a problem with the mattress causing the low-pressure light to be illuminated. If they were unable to resolve the low-pressure problem, they would call the central supply. On 08/13/2025 at 8:15 AM, Resident #2 was observed in bed. The low-pressure light for the air mattress was still illuminated, and the weight setting on the air mattress was set at 170 pounds. During an interview on 08/13/2025 at 8:20 AM, Director of Environmental Services #1 stated that no one had notified them yesterday about the mattress malfunction. During a re-interview on 08/13/2025 at 9:45 AM, Director of Environmental Services #1 stated the work order for the air mattress was put in this morning. The air mattress pump was damaged, which (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	is why the low-pressure light was on. Director of Environmental Services #1 stated they replaced the mattress and the pump today. The low-pressure light indicates a malfunction of some kind and an indication to the nursing staff to alert them (Director of Environmental Services #1). On 08/13/2025 at 2:00 PM, Resident #2 was observed in a Geri chair beside their bed. A new air mattress was in place, and the air mattress's weight setting was set at 350 pounds. On 08/14/2025 at 9:00 AM, Resident #2 was observed in bed. The air mattress's weight setting was set at 350 pounds. During an interview and observation on 08/14/2025 at 9:05 AM, Registered Nurse Supervisor #4 observed the air mattress weight setting of 350 pounds and stated the air mattress should be set according to the resident's weight. Registered Nurse Supervisor #4 did not adjust the weight setting. Registered Nurse Supervisor #4 stated that all the nursing staff were responsible for monitoring the air mattress, and the nurses can adjust the air mattress's weight setting. Registered Nurse Supervisor #4 stated wound care rounds were done today with the wound consultant earlier in the morning, and had no explanation why the air mattress weight setting was set at 350 pounds. During an interview on 08/14/2025 at 10:10 AM, the Assistant Director of Nursing and Educator stated that the Certified Nursing Assistants should alert the nurse of any issues; the nurses can make adjustments to the air mattress setting. The air mattress weight setting should be consistent with the resident's weight. If there is any issue with the mattress, the nurses need to alert the maintenance department through the electronic notification system. During an interview on 08/15/2025 at 8:15 AM, the Director of Nursing Services stated the air mattress weight setting is supposed to be consistent with the resident's weight; all nursing staff are expected to monitor and adjust the weight setting and notify the Maintenance Department of the mattress malfunction through the electronic notification system. During an interview and wound care observation on 08/15/2025 at 9:40 AM, Licensed Practical Nurse Wound Care Nurse #1 stated the air mattress should be checked every shift by nursing staff to ensure proper weight setting and for any malfunctions. The weight setting on the air mattress should be consistent with the resident's weight, and if there is a malfunction, maintenance should be notified. During an interview on 08/15/2025 at 10:55 AM, the Vascular Surgeon, the Wound Care Consultant stated the facility has a protocol to double-check the weight settings on the mattresses on wound rounds and document that the settings were verified. The air mattress weight settings should be consistent with the resident's weight because this helps the wound heal. 10 NYCRR 415.12(c)(1)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, record review, and interviews during the Recertification Survey initiated on 08/11/2025 and completed on 08/15/2025, the facility did not ensure each resident received pharmaceutical services, including procedures that assure the accurate administering of all drugs and biologicals to meet the needs of each resident. This was identified for one (1) (Resident #75) of four (4) residents reviewed for Medication Administration. Specifically, during the medication administration observation for Resident #75 on 08/12/2025, Registered Nurse #6 did not check the placement of the gastrostomy tube before administering the medications.The finding is:The facility's policy titled Medication Administration via Feeding Tube, revised 06/2023, documented disconnect tube feeding (if in progress) and cap the tube; assess resident's abdomen; check tube placement and patency by either aspirating (pulling up with a syringe) gastric contents or auscultating (listening with a stethoscope as air is pushed into the stomach with a syringe) for instilled air.Resident #75 was admitted with diagnoses including Cerebrovascular Accident, Seizure Disorder, and Gastrostomy (feeding tube to stomach) Status. The 04/19/2025 Quarterly Minimum Data Set assessment documented no Brief Interview for Mental Status score, as the resident had severely impaired cognitive skills for daily decision making.The current physician's order documented to check patency of tube feed prior to any medication pass every shift, related to Gastrostomy Status.The current physician's order documented to start enteral feed (tube feeding) in the evening, Type Jevity 1.5, Total Formula Volume 1,200 cubic centimeters per day, Flow Rate 75 cubic centimeters/hour, Start time: 6:00 PM, Check for residual prior to initiation of feeding.During the medication administration observation on 08/12/2025 at 08:20 AM, Registered Nurse #6 prepared the following medications for Resident #75:Vitamin C 500 milligram tablet (supplement).Zinc 50 milligram tablet (supplement).Vitamin B-6 50 milligram tablet (supplement).Multivitamin tablet (supplement).Probiotic capsule (helps maintain a healthy balance of gut bacteria).Furosemide 20 milligram tablet (diuretic).Glycopyrrolate 1 milligram tablet (reduces stomach acid).Keppra Oral Solution 10 milliliters (100 milligrams per milliliter) (for convulsions).After Registered Nurse #6 completed preparing the medications (crushing the tablets because of the gastrostomy tube), the nurse applied all the appropriate personal protective equipment and then entered the resident's room. The nurse disconnected the tube feeding, flushed the tube, but did not check for the placement of the tube.During an interview immediately after the observation, Registered Nurse #6 stated they did not check for the placement of the gastrostomy tube before administering the medications via the tube, and should have.During an interview on 08/14/2025 at 10:10 AM, the Assistant Director of Nursing/Educator stated that the nurses are supposed to check for the placement of the gastrostomy tube by aspirating the gastric contents or by auscultation (listening with a stethoscope as air is pushed into the stomach with a syringe for instilled air) before administering the medications via the tube.During an interview on 08/15/2025 at 8:15 AM, the Director of Nursing Services stated the facility policy requires nurses must check for gastrostomy tube placement before administering medications through a gastrostomy tube.10 NYCRR 415.18(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335156	A. Building B. Wing	08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Shore Rehabilitation and Nursing Center	275 W Merrick Road Freeport, NY 11520

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews during the Recertification Survey initiated on 08/11/2025 and completed on 08/15/2023, the facility did not ensure that it established and maintained an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. This was identified on one (second floor) of two nursing units. Specifically, the facility staff did not utilize appropriate personal protective equipment and did not perform hand hygiene to prevent the spread of infection.The finding is:The facility's policy titled Infection Control/Nursing/Contact Precautions, revised 11/2023, documented to prevent the transmission of organisms among residents, staff, and visitors. The decision to isolate a resident and the type of isolation required are determined by the source of infection, the mode of transmission, and the susceptibility of the host. Resident requiring specific isolation precautions will have a bin outside their room with personal protective equipment and signage indicating to see the nurse before entering the room.Resident #27 was admitted with diagnoses including Cerebrovascular Accident, Seizure Disorder, and Non-Alzheimer's Dementia. The 07/02/2025 Annual Minimum Data Set assessment documented a Brief Interview for Mental Status score of three (3), indicating the resident had severe cognitive impairment. The Minimum Data Set did not document that the resident was under isolation or quarantine for an active infectious disease.Resident #4 was admitted with diagnoses including Diabetes Mellitus, Seizure Disorder, and Respiratory Failure. The 05/17/2025 Annual Minimum Data Set assessment revealed no Brief Interview for Mental Status score, as the resident was in a persistent vegetative state. The Minimum Data Set did not document that the resident was under isolation or quarantine for an active infectious disease.The current physician's order for Resident #27 documented contact precautions related to (VIM CRE) Carbapenem-Resistant Enterobacteriaceae (CRE) (bacteria that have become resistant to some of the strongest antibiotics, including carbapenems) that produce [NAME] Integron-Encoded [NAME]-ˆ-Lactamase (VIM) (an enzyme produced by the bacteria that breaks down the antibiotic).A Comprehensive Care Plan for Resident #27 for Contact Precaution, created on 05/25/2024 and last updated on 07/19/2025, documented to maintain Contact Precautions at all times. Continue with the current care plan. Interventions included applying and removing personal protective equipment as per the Centers for Disease Control guidelines and maintaining contact precautions.The current physician's order for Resident #4 documented contact precautions secondary to Methicillin-resistant Staphylococcus Aureus (MRSA-infection caused by a type of staph bacteria that becomes resistant to many of the antibiotics used to treat ordinary staph infections) in the sputum and related to Carbapenem-Resistant Enterobacteriaceae (CRE) that produce [NAME] Integron-Encoded [NAME]-ˆ-Lactamase (VIM).A Comprehensive Care Plan for Resident #4, created 05/25/2024 and last updated 06/04/2025, documented that the resident was on Contact Precautions. Interventions included instructing family/visitors/caregivers to wear a disposable gown and gloves during physical contact with the resident, discard in the appropriate receptacle, and wash their hands before leaving the room.During an observation on 08/11/2025 at 12:00 PM, a Contact Precaution sign at the entry to Residents #4 and #27's room documented: everyone must clean their hands before entering the room and when leaving the room; put on gloves before room entry; discard gloves before room exit; put on gown before room entry, and discard the gown before room exit.During an observation on 08/11/2025 at 12:00 PM, Licensed Practical Nurse #3 was observed in Residents #4 and #27's room. Licensed Practical Nurse #3 was not wearing any personal protective equipment and was adjusting Resident #27's feeding tube pump.During an interview on 08/11/2025, immediately after the observation, Licensed Practical Nurse #3 stated they were not providing any close contact care and were just adjusting the feeding tube pump because the pump was alarming. Licensed Practical Nurse #3 looked (continued on next page)

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	335156	A. Building B. Wing	08/15/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at the Contact Precaution sign at the door and stated they were not sure whether Residents #4 and #27 were actually on contact precautions. Licensed Practical Nurse #3 did not wash their hands when they exited the room.During an observation on 08/13/2025 at 11:43 AM, Certified Nursing Assistant #3 was observed in Residents #4 and #27's room. Certified Nursing Assistant #3 was not wearing any personal protective equipment and was observed opening and closing drawers and closets.During an interview on 08/13/2025, immediately after the observation, Certified Nursing Assistant #3 stated they had just taken their gown off and placed it in the bin. They stated they should have kept the gown and gloves until they were ready to come out of the room. Certified Nursing Assistant #3 did not wash their hands when they exited the room.During an interview on 08/14/2025 at 10:10 AM, the Assistant Director of Nursing Services/Educator stated that staff are expected to adhere to the contact precautions and follow the instructions on the signage. During an interview on 08/15/2025 at 8:15 AM, the Director of Nursing Services, who was also the Infection Preventionist, stated all staff are expected to adhere to the contact precautions and wear personal protective equipment appropriately, and wash their hands when leaving the room.10NYCRR 415.19(a)(1-3)(b)(4)

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F 0838 Level of Harm - Potential for minimal harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews during the Recertification Survey initiated on 08/11/2025 and completed on 08/15/2025, the facility did not ensure its Facility Assessment considered specific staffing needs for each resident unit. This was identified during the Sufficient Nursing Staffing Task. Specifically, the Facility Assessment, last reviewed in July 2025, did not indicate nursing staffing (Certified Nursing Aides, Licensed Practical Nurse, and Registered Nurse) needs for each resident unit. The finding is:The facility's undated policy titled Facility Assessment documented the facility will evaluate its resident population and identify the resources needed to provide the necessary person-centered care and services the residents require. A detailed review of the resident population that included, but was not limited to resident census data, resident capacity, factors that affect the overall acuity of the residents, physical characteristics of the facility, and services currently provided. A review of the Facility assessment dated [DATE] revealed the Facility Assessment did not identify the resident units in the facility and did not indicate specific nursing staffing needs for each resident unit.During an interview on 08/12/2025 at 2:24 PM, the Administrative Assistant stated the facility had two (2) resident units (first and second floors) and they were responsible for the nursing staffing schedule for both floors. During an interview on 08/14/2025 at 1:49 PM, the Administrator stated they were responsible for developing and reviewing the Facility Assessment. The Administrator stated that the Facility Assessment did not consider specific nursing staffing needs per resident unit because they (the Administrator) were not aware that it was a requirement. The Administrator stated that nursing staffing needs should be considered by the first and second floors. During an interview on 08/14/2025 at 2:24 PM, the Director of Nursing Services stated they did not directly participate in developing the Facility Assessment but would provide input if necessary. The Director of Nursing Services stated they did not know that nursing staffing needs must be considered per resident unit. The Director of Nursing Services stated the Facility Assessment did not and should have considered the nursing staffing needs for each. 10 NYCRR 415.26