STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335158	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oceanside Care Center Inc	2914 Lincoln Avenue Oceanside, NY 11572

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50423 Based on record review and interviews and during the Recertification Survey initiated on 11/7/2024 and completed on 11/14/2024, the facility did not ensure an assessment was completed to accurately reflect a resident's status. This was identified for one (Resident #55) of one resident reviewed for Physical Restraints. Specifically, Resident #55 had physician orders for the use of a floor mat alarm and a wheelchair alarm. Resident #55's quarterly Minimum Data Set assessments dated 10/29/2024 and 8/3/2024 did not accurately reflect the use of the chair alarm and the floor mat alarm. The finding is: The facility's policy titled Comprehensive Assessment and Comprehensive Care Planning Process effective 1/2000 and last revised in 12/2023 documented the interdisciplinary team is responsible for Resident Assessments and completion. The Minimum Data Set Coordinator is responsible for coordinating the assessment and care planning process in order to ensure the timely and accurate completion of the Minimum Data Set assessment and care plan. Resident #55 was admitted with diagnoses including a history of Falling, Difficulty in Walking, and Dementia. The quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 5, indicating the resident had severe cognitive impairment. The Minimum Data Set assessment, section P0200 Alarms, documented the resident did not use a floor mat alarm and a chair alarm. The quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 5, indicating the resident had severe cognitive impairment. The Minimum Data Set assessment, section P0200 Alarms, documented the resident did not use a floor mat alarm and a chair alarm. The Comprehensive Care Plan titled At Risk for Falls last revised 4/1/2024 documented interventions including the use of a chair alarm and a floor mat alarm with consent from the resident's family. A Physician's Order dated 3/28/2024 and last renewed on 11/11/2024 documented the application of a chair alarm with consent from the resident's family. A Physician's Order dated 4/1/2024 and last renewed on 11/11/2024 documented the application of a floor mat alarm with consent from the resident's family. (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/14/2024 at 10:55 AM, the Minimum Data Set Coordinator stated they were responsible for scheduling, completing, and submitting the Minimum Data Set assessments. The Minimum Data Set Coordinator stated when they completed an assessment, they reviewed the resident's chart, the physician's orders, progress notes, and care plans and saw the resident in person as well. They stated the quarterly Minimum Data Set assessments for Resident #55 dated 8/3/2024 and 10/29/2024 should have reflected the use of a chair alarm and floor mat alarm. The Minimum Data Set Coordinator stated this was an error on their part. During an interview on 11/14/2024 at 11:20 AM, the Director of Nursing Services stated they agreed with the Minimum Data Set Coordinator's answer that this was a human error. The Director of Nursing Services further stated the Minimum Data Set Coordinator should have paid more attention to the interventions for fall prevention as the resident had a history of falls. The Director of Nursing Services stated the floor mat alarm and chair alarm were in use during the assessment periods and the assessment should have accurately reflected the use of both alarms. 10 NYCRR 415.11(b)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 34798 Based on record review and interviews during the Recertification Survey initiated on 11/7/2024 and completed on 11/14/2024 the facility did not ensure that each resident who was prescribed psychotropic drugs (drugs that affect the mind, emotions, and behavior by altering the chemical makeup of the brain and nervous system) received gradual dose reductions unless clinically contraindicated. This was identified for one (Resident #25) of five residents reviewed for Unnecessary Medications. Specifically, Resident #25 was receiving Risperidone (also known as Risperdal, an antipsychotic medication) 0.5 milligrams in the morning and 1.25 milligrams at bedtime. On 3/6/2024 the Psychiatrist and on 9/12/2024 a Pharmacist recommended a gradual dose reduction. There was no documented clinical contraindication to attempt Risperdal gradual dose reduction for Resident #25. The facility did not attempt the gradual dose reduction because the resident's representative did not agree with the Psychiatrist's and the Pharmacist's recommendations. The finding is: The facility's policy, titled Psychotropic Medication, reviewed/revised 2/2024, documented under the heading Antipsychotics, Residents must, unless clinically contraindicated, have a gradual dose reduction of the antipsychotic drug. Clinically contraindicated means: For residents who have had a history of recurrence of psychotic symptoms which have been stabilized with a maintenance dose of an antipsychotic drug without incurring significant side effects. The physician will not initiate dose reduction and will document the same, and for residents for whom a gradual dose reduction has been attempted twice in one year and that attempt resulted in the return of symptoms for which the drug was prescribed, the physician will not continue dose reduction attempts and will document same. Resident #25 was admitted with diagnoses including Vascular Dementia, Nontraumatic Intracranial Hemorrhage (brain bleed), and Aphasia (a language disorder that affects a person's ability to understand and express written and spoken language). The 10/24/2024 Annual 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 assessment documented antipsychotic medications were received on a regular basis, there was no gradual dose reduction attempted, and the Physician did not document that a gradual dose reduction was clinically contraindicated. A physician's order dated 2/15/2024 documented Risperdal oral tablet 0.5 milligrams, one tablet by mouth every day (9:00 AM), for a diagnosis of mood changes. A physician's order dated 3/7/2024 documented Risperdal oral tablet 1.0 milligrams, and 0.25 milligrams (a total of 1.25 milligrams) by mouth at bedtime, for a diagnosis of Delirium due to known physiological condition. A Psychiatrist consult dated 3/26/2024 documented the resident was taking Risperdal 0.5 milligram in the morning and 1.25 milligrams at bedtime for diagnosis of Mood Disorder secondary to Cerebrovascular Accident and Vascular Dementia. The Psychiatrist recommended lowering the bedtime dose to 1 milligram at bedtime instead of 1.25 milligrams. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note dated 3/26/2024, written by Registered Nurse #1 (the Unit Manager), documented the resident was seen by the Psychiatrist. Risperdal was decreased to 0.5 milligrams in the morning and 1.0 milligrams at bedtime. A review of the March 2024 Medication Administration Record revealed that the resident received 1.0 milligrams of Risperdal for one day on 3/26/2024 at 9:00 PM. A progress note dated 3/27/2024, written by Registered Nurse #1, documented the resident's family member did not want the resident seen by the Psychiatrist anymore and wanted the Risperdal order changed back to 0.5 milligrams in the morning and 1.25 milligrams at bedtime. No further psychiatry consults are to be done. A physician's order dated 3/27/20204 documented adding Risperdal 0.25 milligrams at bedtime (in addition to the 1.0 milligrams Risperdal order already in place). A review of the March 2024-November 2024 Medication Administration Records revealed except for 3/26/2027, Resident #25 consistently received 0.5 milligrams of Risperdal at 9:00 AM and 1.25 milligrams of Risperdal at bedtime for a diagnosis of Mood Disorder. A Pharmacist Medication Regimen Review dated 9/12/2024 documented [Resident #25] is currently receiving Risperidone (Risperdal) for a diagnosis other than an approved chronic psychiatric condition. Please evaluate the continued need and efficacy. Consider tapering Risperdal to 0.5 milligrams in the morning and 1 milligram at bedtime. Physician #1 agreed with the recommendations on 9/18/2024. A review of September 2024 through 11/12/2024 Medication Administration Records indicated that no changes to the Risperdal orders were made. A progress note dated 9/18/2024, written by Registered Nurse #1 (unit manager), documented the resident's family did not want the Risperdal dosage decreased. On 11/7/2024 at 10:54 AM Resident #25 was observed in the day room. The resident was sleeping but arousable. The resident was not interviewable. During an interview on 11/12/2024 at 11:48 AM, Physician #1 (the house/covering Physician who marked Agree on the pharmacy review) stated the Risperdal dosage as recommended by the Pharmacist, was not decreased because the resident's family member did not want the medication dosage changed. Physician #1 stated they do not alter the residents' medications unless the residents' families agree. Physician #1 stated Risperdal is not the drug of choice for Delirium and that the use of the Delirium diagnosis was a mistake. During an interview on 11/12/2024 at 12:02 PM, Registered Nurse #1 stated the resident's (Resident #25) family member does not let us do anything and that is why we could not decrease the Risperdal dosage. On 11/12/2024 at 1:55 PM Resident #25 was observed in the day room sleeping. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/12/2024 at 1:58 PM, Physician #2 (the Primary Attending Physician) stated they were not made aware of the recommendations for Risperdal gradual dose reduction and refusal by the resident's family member. Physician #2 stated there has to be a clinical contraindication for not attempting a gradual dose reduction for psychotropic medications. Physician #2 stated if they knew, they would have had a conference call with the family member, the Psychiatrist, and themselves to find out why the family member did not want the gradual dose reduction. During an interview on 11/12/2024 at 2:19 PM, the Director of Nursing Services stated the primary Physician should have been made aware of the recommendation for Risperdal gradual dose reduction. The Director of Nursing Services stated the gradual dose reduction was attempted for one day (3/26/2024), but the resident's family member got very upset and Risperdal was changed back to the original dosage of 1.25 milligrams at bedtime. The Director of Nursing Services stated they knew there should be a clinical reason for not attempting a gradual dose reduction of psychotropic medication, but the resident's family member insisted on continuing the same Risperdal dosage. The Director of Nursing Services stated they spoke with the resident's family member regarding recommendations for Risperdal gradual dose reduction made by the Psychiatrist but did not document their discussions with the family member in the resident's medical record. 10 NYCRR 415.12(l)(2)(ii)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45349 Based on observation, record review, and interviews during the Recertification Survey initiated on 11/7/2024 and completed on 11/14/2024, the facility did not ensure that food was stored, prepared, distributed, and served in accordance with professional standards for food service safety. This was evident during the Kitchen observation conducted on 11/13/2024. Specifically, the facility did not monitor the temperature of cold food items (sandwiches, tartar sauce), at the time of meal service. The finding is: A facility policy and procedure titled Food Distribution and Service dated August 2024 documented the facility will distribute and serve food items to the residents in a safe manner, thereby maintaining holding temperatures and safe, covered transportation of food to the resident population. Cold food items will be bathed in ice, except for sandwiches which will be refrigerated for the duration of the tray line. Whether hot or cold holding, all foods will be kept out of the danger zone. Cold holding temperatures will be sampled and recorded. An observation of the kitchen on 11/13/2024 at 11:57 AM revealed a tray of plastic cups of tartar sauce on the cooks' table. The tray was not on an ice bath. The individual resident meal trays were arranged on a food cart, some with sandwiches already placed on them. During an interview on 11/13/2024 at 12:12 PM, the [NAME] stated that the tartar sauce should be served cold and should be kept on ice. During an interview on 11/13/2024 at 12:14 PM, the Dietary Manager stated that no cold food temperatures were taken for this meal and they do not have a temperature log for the cold food items. The Dietary Manager took the temperature of the tartar sauce, and it registered 48 degrees Fahrenheit. The temperature of a tuna sandwich was also taken and registered at 46 degrees Fahrenheit. The Dietary Manager stated that the cold food should be at a maximum temperature of 40 degrees Fahrenheit. During an additional interview on 11/13/2024 at 2:15 PM, the Dietary Manager stated that the tartar sauce should have been stored on ice. The Dietary Manager stated that it is important to keep temperatures below 40 degrees Fahrenheit for food safety, to prevent food-borne illness, and the growth of bacteria or spores. 10 NYCCR 415.14(h)