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	01/05/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility did not ensure that a resident who was unable to carry out activities of daily living received the necessary services to maintain good grooming and personal hygiene. This was identified for one (1) (Resident #5) of one (1) resident reviewed for Activities of Daily Living. Specifically, Resident #5 was observed multiple times with long, dirty fingernails. There was no documented evidence that the resident refused to have their nails cut and/or cleaned by staff.The finding is: The facility policy titled Activities of Daily Living last revised 03/03/2025, documented residents will be provided with care, treatment, and services appropriate to maintain or improve their ability to carry out activities of daily living. Appropriate care and services will be provided for residents who are unable to carry out activities of daily living independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene (bathing, dressing, grooming, and oral care). The resident's response to interventions will be monitored, evaluated, and revised as appropriate. The Certified Nursing Assistant job description included providing appropriate nail and hair care for each resident. Resident #5 was admitted with diagnoses including non-Alzheimer's dementia, schizophrenia, and lack of coordination. The Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 9, indicating the resident had moderate cognitive impairment. The resident required partial/moderate assistance for personal hygiene and had no behaviors and did not reject care. A comprehensive care plan titled Activities of Daily Living, initiated on 02/14/2025 documented interventions including provide assistance with activities of daily living, including grooming, establish customary routine for activity of daily living that is agreeable to the resident. There was no documented evidence that the resident refused care. A review of the electronic medical record revealed no documented evidence of the resident's non-compliance with care. During observations on 12/29/2025 at 3:37 PM, 12/31/2025 at 9:26 AM and 12/31/2025 at 1:29 PM, Resident #5 was observed with long, dirty fingernails. During an interview on 12/31/2025 at 1:20 PM, Certified Nursing Assistant #2 stated the resident refused to let them cut or clean their fingernails and was not cooperative with the daily care. Certified Nursing Assistant #2 further stated they told the nurse (could not recall name) when the resident refuses care. During an interview on 12/31/2025 at 1:25 PM, Licensed Practical Nurse #2 stated the Certified Nursing Assistants were responsible for providing hygiene and grooming care for the resident. Licensed Practical Nurse #2 stated they were not made aware Resident #5 refused to have their fingernails trimmed and cleaned. Licensed Practical Nurse #2 stated if they were aware, they would have intervened. Licensed Practical Nurse #2 stated that a note in the Activities of Daily Living care plan and a non-compliant care plan should have been initiated. During an interview on 01/02/2026 at 8:49 AM, the Director of Nursing Services stated that the Certified Nursing Assistant should have reported to the nurse or any nursing administration staff when the resident was not complying with their activities of daily living tasks. 10 NYCRR 415.12(a)(3)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. Based on observations, record review, and interviews, the facility did not ensure that each resident with pressure ulcers received necessary treatment and services consistent with professional standards of practice to promote healing, prevent infection, and prevent new ulcers from developing. This was identified for one (1) (Resident #105) of three (3) residents reviewed for Pressure Ulcers. Specifically, Resident #105 had multiple pressure ulcers to the right heel, right lateral (side) leg, and left buttock and utilized an air mattress as an intervention as per the plan of care. During multiple observations, the adjustable weight setting on the air mattress pump was not set according to the resident's actual weight.The finding is:The facility's policy titled, Skin Prevention: Air Mattress dated 03/03/2025 documented to ensure that all staff involved in the use of air mattresses for skin prevention are knowledgeable about the care and maintenance of the air mattresses and proper positioning of the resident on the air mattress. The Wound Care Nurse/designee will obtain the [resident's] initial weight and perform weight calibration for the air mattress. Nursing staff will be responsible for checking for proper inflation, functionality, and settings of the air mattress and for making changes as appropriate.The Alternating Pressure and Low Air Loss Mattress System operation manual documented to verify that the resident's weight does not exceed the weight capacity of the bed frame, bed rails or the [air] mattress system. The instructions documented to simply press the weight button to adjust the weight setting from 100 pounds to 325 pounds, according to the resident's weight.Resident #105 was admitted with diagnoses including respiratory failure, sepsis (body's extreme response to an infection) and cerebral infarction (death of a brain tissue caused by blockage of a blood vessel). The Minimum Data Set assessment was not completed for Resident #105 as the resident was recently admitted to the facility.A review of the Braden Scale (for predicting pressure sore risk) dated 12/31/2025 documented a score of 14, which indicated Resident #105 was at a moderate risk of developing pressure ulcers.The electronic medical record dated 12/22/2025 documented that Resident #105 weighed 128.3 pounds.The Comprehensive Care Plan (CCP) titled, Skin Prevention dated 12/22/2025 documented interventions including skin barrier with incontinence care, turning and positioning as per schedule, and using an alternating pressure air mattress.The Wound Care Note dated 01/05/2026 documented Resident #105 had an Unstageable (full thickness skin and tissue loss where the base is obscured by dead, yellowish or brown/black tissue) wound on the right lateral heel measuring 3.0 centimeters length, 2.0 centimeters width and 0.1 centimeters depth; a Deep Tissue Injury (damaged soft tissue from prolonged pressure) on the right heel measuring 3.0 length and 2.0 width; and a Stage Three (3) pressure ulcer (full thickness skin injury where the skin breaks down, revealing the fatty tissue underneath) on the left buttock measuring 0.5 centimeters length, 1.5 centimeters width and 0.1 centimeters depth.A Physician's Order dated 12/22/2025 documented cleansing the right heel with normal saline, pat dry and applying betadine solution and cover with dry protective dressing daily; and cleansing the right lateral (side) leg with normal saline, pat dry and apply dry protective dressing daily.A Physician's Order dated 12/30/2025 documented cleansing the left buttock with normal saline and applying triad ointment (local wound treatment) then cover with border gauze dressing daily.A Physician's Order dated 12/31/2025 documented to monitor the alternating pressure air mattress for proper inflation corresponding to resident's weight, every shift.During an observation on 12/29/2025 at 10:05 AM, Resident #105 was lying in bed. The air mattress weight setting was set at 250 pounds.During an observation on 12/30/2025 at 11:44 AM, Resident #105 was lying in bed. The air mattress weight setting was set at 250 pounds.During an observation 12/31/2025 at 9:45 AM with Licensed Practical Nurse #2, Charge Nurse, Resident #105 was sitting in the wheelchair in their room. The air mattress weight setting was set at 250 pounds.During an interview on 12/31/2025 at 9:58 AM, Licensed Practical Nurse #2, Charge Nurse, stated that the unit nurses were responsible for checking the air mattress weight setting. Licensed Practical Nurse #2 stated that the air mattress weight setting (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should be set within the range of Resident #105's weight.During an interview on 12/31/2025 at 10:05 AM, Licensed Practical Nurse #1, the medication nurse, stated they should be checking the air mattress setting every day; however, they did not check the weight setting on the air mattress for Resident #105 on 12/29/2025 and it was an oversight.During an interview on 12/31/2025 at 11:45 AM, Licensed Practical Nurse #3, the treatment nurse who was covering for the Wound Care Nurse, stated that nurses were responsible for ensuring that the air mattress weight setting was set according to the resident's weight. Licensed Practical Nurse #3 stated they administered wound care to Resident #105 on 12/30/2025 and did not check the air mattress weight settingDuring an interview on 12/31/2025 at 2:04 PM, the Wound Care Nurse Practitioner stated the air mattress assists with wound healing and prevention of further skin breakdown and that the air mattress weight setting should be set within the resident's weight range.During an interview on 01/02/2026 at 11:48 AM, the Director of Nursing Services stated that the air mattress weight setting at 250 pounds for Resident #105 was too high. The Director of Nursing Services stated they expected the Nurses to check for the air mattress weight setting as per the physician's orders. 10 NYCRR 415.12(c)(1)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews the facility did not ensure each resident admitted with an indwelling urinary (Foley) catheter is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary. This was identified for one (1) (Resident #1) of one (1) resident reviewed for urinary catheter. Specifically, Resident #1 had a Foley catheter; however, there was no clear indication in the medical record regarding when the catheter was first inserted, there was no physician's order for the use of the catheter, and no documented evidence that a trial of void was attempted.The finding is:The facility policy titled Catheterization, last revised 03/20/2025, documented that catheterizations are used only when essential and medically indicated. Catheterizations require a physician's order. Indwelling catheters are used only when medically necessary, as in neurogenic bladder, or Stage IV pressure ulcer to decrease urinary incontinence.The facility policy titled Interdisciplinary Care Plan, last revised 03/15/2025, documented the comprehensive care plan is reviewed at least quarterly and revised as necessary by the interdisciplinary team after each comprehensive assessment.Resident #1 was admitted with diagnoses including diabetes mellitus, seizure disorder, and chronic obstructive pulmonary disease. The Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 3, indicating the resident had severe cognitive impairment. The resident did not have a Foley catheter, and did not have any genitourinary (combines the urinary and reproductive systems) diagnoses.A nursing admission assessment dated [DATE] documented that Resident #1 was admitted to the facility with a Foley catheter.A Comprehensive Care Plan titled Foley Catheter effective 12/18/2024 documented the resident had a size 16 French Foley catheter with a 10 cubic centimeter balloon for urinary retention as of 12/13/2024.There was no documented evidence of a physician's order for the use of the Foley catheter. A physician's order dated 01/20/2025 documented trial of voiding to be done on 01/21/2025 at 12:00 AM; if resident is unable to urinate after eight (8) hours, reinsert Foley catheter.Review of nursing progress notes from 01/21/2025 onward revealed that the trial of voiding was completed as ordered and the resident was able to urinate spontaneously without the need of a Foley catheter. The Foley Catheter care plan was updated to indicate successful voiding trial.Review of the medical record indicated the resident was discharged to the hospital on [DATE] and was re-admitted on [DATE] with diagnosis of pneumonia. There was no indication in the 10/06/2025 nursing admission progress note that the resident was re-admitted to the facility with a Foley catheter.Review of the medical record revealed no physician's order for the Foley catheter since 10/06/2025. A nursing progress note dated 11/24/2025 at 10:36 AM documented Foley catheter changed this tour.The physician's order dated 11/25/2025 documented Foley catheter care (every shift).The November 2025 and December 2025 Treatment Administration Record revealed Foley catheter care was provided each shift beginning 11/25/2025.A physician progress note dated 12/05/2025 and 12/06/2025 documented Foley catheter was in place for neurogenic bladder (nerve damage that disrupts brain-bladder communication and affects holding or emptying urine). A nursing progress note dated 12/09/2025 documented Foley catheter was noted with cloudy and pinkish urine in the tubing. Foley catheter clogged and an attempt to flush the Foley catheter was unsuccessful. Foley catheter was removed. A new Foley catheter French 16 was inserted. 100 cubic centimeters cloudy urine with sediments was obtained. A nursing progress note dated 12/30/2025 at 2:04 PM, written by Registered Nurse Supervisor #1, documented (late entry for 12/23/2025) -the resident had a Foley catheter changed today, draining adequate amber color urine with no complaints of pain/discomfort.An update to the Foley Catheter care plan dated 12/30/2025 documented late entry for 12/23/2025; resident had Foley catheter change today to replace 16 French with 10 cubic centimeter balloon, in place and draining adequate amber urine, no complaints of (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pain/discomfort, will continue to monitor. There were no updates to the Foley catheter care plan since 10/06/2025 indicating when the Foley catheter was inserted.During an interview on 12/30/2025 at 2:53 PM, Registered Nurse Supervisor #1 stated the resident care plans should be updated at least quarterly and when there is a change in the plan of care. Resident #1's care plan for the Foley catheter was not updated and that may have been due to change of staff. Registered Nurse Supervisor #1 stated Resident #1 received the Foley catheter in the hospital and had the Foley catheter present when they were admitted to the facility on [DATE]. Registered Nurse Supervisor #1 stated they did not know that a trial void was needed.During a re-interview on 12/31/2025 at 11:41 AM, Registered Nurse Supervisor #1 stated a trial of voiding would be attempted for Resident #1 to see if the resident could urinate on their own. Registered Nurse Supervisor #1 stated Resident #1 had a Foley catheter when they returned from the hospital on [DATE] that I am sure of. When the resident returned to the facility with a Foley catheter, there should have been a physician's order in place for the use of the Foley catheter with the indication. Review of the medical record revealed that from 10/06/2025 to 12/31/2025 there was no attempt of a trial of voiding.During an interview on 12/31/2025 at 11:55 AM, Assistant Director of Nursing Services #1 stated when a resident is utilizing a Foley catheter, there should be a physician order for the catheter use and the order should also include the indication for the catheter use. The comprehensive care plans should be updated at least quarterly by the unit nurses. A nursing progress noted dated 01/01/2026 at 3:32 PM, documented Resident #1to start supervised trial voiding on 01/02/2026 as per the physician. Remove the Foley catheter in the morning. If trial of voiding fails, the resident will require continued chronic Foley catheter, and a urology follow up. During an interview on 01/02/2026 at 8:45 AM, the Director of Nursing Services stated they did not know when the Foley catheter was inserted for Resident #1, and they were reviewing the resident's records to figure it out. The Director of Nursing Services stated the medical record should include a physician's order with indication for the Foley catheter use and documentation demonstrating when the Foley catheter was first inserted. The Director of Nursing Services stated Resident #1's care plans should have been updated by the unit nurses to reflect the status of the Foley catheter; if the resident was readmitted to the facility in October 2025 with a Foley catheter, the trial of voiding probably should have been done within two weeks.A nursing progress note dated 01/03/2026 at 2:39 PM documented day two for trial voiding after the Foley catheter removal. The resident was noted with a urine saturated brief.10 NYCRR 415.12(d)(1)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews the facility did not ensure that medications and biologicals were stored in accordance with accepted professional standards of practice. This was identified for one of one medication storage room. Specifically, upon observation of the medication storage room on 12/30/2025, the medications were stored in a disorganized manner with boxes containing discontinued medications and medications that belonged to residents who expired or were no longer in the facility.The finding is:The facility's policy titled Medication Storage, last revised 03/12/2025, documented medications must be stored in accordance with manufacturer's specifications and secured in a locked storage areas in compliance with state and federal requirements and accepted professional standards of practice.On 12/30/2025 at 09:45 AM, during an observation of the medication storage room on Unit 2 with Licensed Practical Nurse #6 (medication nurse/charge nurse), the following observations were made: the medication storage room was disorganized and cluttered with bottles of tablet medications, boxes of inhaler medications, and bottles of liquid medications (cough syrups, lactulose) disorganized and all stored together on a shelf. There was a full box of discontinued blister pack medications on the floor. A box of antibiotic Fidaxomicin 200 milligram tablets ordered for Resident #65 on 08/06/2025 and last used in August 2025 (as per the 08/2025 medication administration record) was stored on the shelf. Multiple boxes of inhaler treatments with labels for Resident #38 (resident expired 12/17/2025); Resident #106 (resident expired 09/23/2025), Resident #107 (resident expired 10/17/2025), and Resident #108 (transferred to hospital on [DATE] and did not return to the facility) were stored in the medication room. Cans of unopened cola; a package of Fig Newtons; a package of food syrup; and a coat hanger was observed lying in a box of unused syringes. Licensed Practical Nurse #6 stated the food items should not be stored in the medication storage room. Licensed Practical Nurse #6 stated discontinued blister packs and medications for the discharged residents were supposed to be delivered to the nursing office and then sent back to the pharmacy. Licensed Practical Nurse #6 did not know why the medications for the discharged residents were still stored in the medication storage room. During an interview on 12/30/2025 at 11:13 AM, Assistant Director of Nursing Services #1 stated the night shift nursing staff were responsible for keeping the medication storage room clean and tidy. The food items were not supposed to be in the medication storage room. Assistant Director of Nursing Services #1 stated nurses should bring the discharged residents' medications to the nursing office right after the residents were discharged and then the medications should be returned to the pharmacy.During an interview on 01/02/2026 at 8:45 AM, the Director of Nursing Services stated food items should not be stored in the medication storage room. When a resident is discharged , the discontinued medications should be brought to the nursing office to be returned to the pharmacy. The medication storage room should be organized and clean. 10 NYCRR 415.18(e)(1-4)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and interviews, the facility did not ensure that each resident's medical records were in accordance with accepted professional standards and practices and were complete and accurately documented. This was identified for one (1) (Resident #39) of five (5) residents reviewed for Unnecessary Medications. Specifically, Resident #39 had a physician's order for Tramadol (a controlled substance used to treat pain). A review of the narcotic tracking sheet for December 2025 revealed Tramadol 50 milligrams tablet was removed from the blister pack on 12/12/2025, 12/23/2025, and 12/27/2025; however, there was no documentation on the medication administration record to indicate the medication was administered to Resident #39.The finding is:The facility's policy titled Medication Administration and Documentation, effective 4/10/2025, documented that the Medication Administration Record is the form onto which all medication orders are transcribed, from which medications are poured and administered and on which medication doses are charted. The Medication Administration Record is a permanent part of the resident's medical record. Licensed nurses document administration of medication on the medication administration record immediately following administration. Resident #39 was admitted with diagnoses including cerebral palsy, right leg and right-hand pain. The 10/02/2025 Quarterly Minimum Data Set assessment documented a Brief Interview for Mental Status score of 13, indicating the resident was cognitively intact.A physician's order dated 11/21/2025 documented Tramadol HCL oral tablet 50 milligrams every 12 hours as needed; If pain level is greater than five (5) then administer the medication.The narcotic tracking sheet dated 12/12/2025 the narcotics tracking sheets documented the administration of a 50 milligrams tablet of Tramadol HCL at 2:00 PM. with no documentation of reported pain or the administration of the medication on the medication administration record.The narcotic tracking sheet dated 12/23/2025 documented the administration of a 50 milligrams tablet of Tramadol HCL at 11:08 AM with no documentation of reported pain or the administration of the medication on the medication administration record.The narcotic tracking sheet dated 12/27/2025 documented the administration of a 50 milligrams tablet of Tramadol HCL at 9:00 AM with no documentation of reported pain or the administration of the medication on the medication administration record.During an interview on 1/02/2026 at 11:55 AM, Licensed Practical Nurse #7 (the medication nurse that administered the Tramadol on 12/23/2025 stated they had administered and documented the pain medication according to the physician's orders. Licensed Practical Nurse stated they were not sure why the medication administration record did not display their signature to indicate that Tramadol was administered to Resident #39. During an interview on 01/05/2026 at 12:45 PM, Registered Nurse #2 (the medication nurse that administered the Tramadol on 12/12/2025) stated they had administered Tramadol medication to Resident #39 on 12/12/2025; however, they must have forgotten to document on the medication administration record.During an interview on 01/05/2026 at 12:50 PM, Licensed Practical Nurse #8 (the medication nurse that administered the Tramadol on 12/27/2025) stated they had administered the Tramadol medication to Resident #39 on 12/27/2025 but forgot to go back to sign the medication administration record because they were called away to address another resident in need. During an interview on 01/05/2026 at 1:00 PM, the Director of Nursing Services stated the nurses should document the administration of the medication on the narcotics tracking sheets and the medication administration record. The Director of Nursing Services further stated the nurses should also document the level of pain reported by the resident and the effectiveness of the pain medication on the medication administration record.10 NYCRR 415.22(a)(1-4)