STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335159	A. Building B. Wing	01/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ross Center for Nursing and Rehabilitation	839 Suffolk Avenue Brentwood, NY 11717

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Based on observations, interviews, and record review, the facility did not maintain all mechanical, electrical, and patient care equipment in safe operating condition. This was identified during the Kitchen Task. Specifically, during follow-up kitchen tours on 01/15/2026 and on 01/16/2026, the walk-in freezer temperatures were observed to be 26 degrees Fahrenheit (the food safety requirement should be at or below zero (0) degree Fahrenheit). Additionally, one (1) of the three (3) evaporator fans in the walk-in freezer were not operational. The finding is: The facility policy and procedure titled Food Storage dated 01/13 documented all perishable foods are stored in either refrigerators maintained at 41 degrees [Fahrenheit] or below, or freezers at zero (0) degree [Fahrenheit], or below respectively. A reliable thermometer shall be installed and maintained in all refrigeration and freezer units and monitored on a daily basis. The United States Food and Drug Administration Refrigerator and Freezer Storage Chart dated March 2018 documented freezing [temperature] of zero (0) degree Fahrenheit (-18 degree Celsius) keep food safe indefinitely. During an interview on 01/13/2026 at 9:37 AM, the Director of Food Services stated that there was no equipment that was non-operational, except for a broken lock on the chemical room door. The Director of Food Services stated there were no outstanding work orders for any kitchen equipment, including all refrigeration units. During a follow-up kitchen tour with the Director of Food Services on 01/15/2026 at 9:53 AM, the outside thermometer gauge of the walk-in freezer indicated a temperature of 20 degrees Fahrenheit. A free-standing thermometer inside the walk-in freezer indicated temperature of 26 degrees Fahrenheit. Three (3) overhead evaporator fans were observed; the fan on the left was not operational. The middle fan and the fan on the right were spinning. The walk-in freezer temperature log for January 2026 indicated the temperature on 01/15/2026 at 6:00 AM was -10 degrees Fahrenheit. During an interview on 01/15/2026 at 9:53 AM, the Director of Food Services stated that they were not aware of the walk-in freezer temperature issue. The Director of Food Services stated that the walk-in freezer temperature should be maintained at zero (0) degree Fahrenheit or below. The Director of Food Services was not certain why the temperature was out of range. The Director of Food Services stated they were aware that the walk-in-freezer overhead fan on the left was not working and thought that the fan turned off as part of the unit defrosting process and they did not submit any repair order for the evaporator fan. During a follow-up kitchen tour with the Director of Environmental Services on 01/15/2026 at 02:45 PM, the outside thermometer gauge for the walk-in freezer indicated a temperature of 12 degrees Fahrenheit. A free-standing thermometer inside the walk-in freezer indicated temperature of 22 degrees Fahrenheit. The Director of Environmental Services stated the walk-in freezer temperature was out of range because the door was not shut properly. During a follow-up kitchen tour with the Director of Food Services and the Director of Environmental Services on 01/16/2026 at 09:37 AM, the outside thermometer gauge for the walk-in freezer indicated a temperature of 14 degrees Fahrenheit. A free-standing thermometer inside the walk-in freezer indicated temperature of 26 degrees Fahrenheit. The evaporator fan on the left was still off while the middle fan and the fan on the right were spinning. During an interview on 01/16/2026 at 09:40 AM, the Director of Environmental Services stated that the fans were on alternate cycles for defrosting and there were always only two fans that were spinning at the same (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	time. The Director of Environmental Services stated they considered the evaporator fans operational. The Director of Environmental Services stated a technician has been called to service the walk-in freezer. During an interview on 01/16/2026 at 12:24 PM, the technician from servicing company stated the walk-in freezer should be maintained at zero (0) degree Fahrenheit or below to keep the food frozen solid. The technician stated the walk-in freezer compressor (a machine responsible for compressing refrigerant to cool the freezer) required additional refrigerant (a special fluid that absorbs heat from one area and releases it in another) due to pressure changes. The technician stated the freezer temperature was elevated because of inadequate refrigerant fluid. The technician stated the evaporator fans circulated air inside the freezer. The technician stated a non-operational fan will impact areas inside the walk-in freezer where there may be lack of air flow, causing ice buildup and gradual increase in temperature. The technician stated the evaporator fan on the left was off during their inspection and they (the technician) found loose connecting wire. The technician stated they tightened the wire, and the fan is now operational. The technician stated all three fans should be running simultaneously during non-defrosting cycle. The technician stated they were not called for servicing the walk-in freezer prior to today, 1/16/2026. 10 NYCRR 415.5(e)(1)(2)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility did not immediately inform the resident's Physician when there was a significant change in the resident's physical, mental, or psychological status (that is, a deterioration in health, mental, or psychological status in either life threatening conditions or clinical complications). This was identified for one (1) (Resident #84) of two (2) residents reviewed for Nutrition. Specifically, on 12/15/2025 Resident #84 was identified with an undesired significant weight loss of 5% in one month, and on 1/16/2026 an undesired significant weight loss of 10.2% in 3 months. There was no documented evidence that the resident's Physician was notified of the resident's significant weight loss.The finding is: The facility's policy titled, Resident Change in Condition last revised in 10/2025 documented should a resident experience a medical change in condition that indicates an emergency of acute illness, it is the expectation that the Registered Nurse on duty will perform a full assessment of the resident and document such change in the medical record and notify the Physician of such changes. Upon determining that a change in the resident's condition has occurred, the licensed nurse on duty will promptly notify the Registered Nurse Supervisor on duty and make him/her aware. A change in condition may include but is not limited to: A significant change in the resident's physical/emotional, mental condition. Resident #84 had diagnoses that included hypertension (abnormally high blood pressure) and type 2 diabetes mellitus (a form of diabetes mellitus characterized by high blood sugar, insulin resistance, and lack of insulin). The Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented the resident had severely impaired cognitive skills for daily decision making with long- and short-term memory problems. The Minimum Data Set documented the resident's height was 63 inches and weight was 121 pounds. The resident had no weight loss of 5% or more in the last month or a loss of 10% of more in the last six (6) months and was not on a physician-prescribed weight-loss regimen. The Dietary Progress Note dated 12/11/2025, written by Registered Dietitian #1, documented: Resident noted with a 5.4 pounds decrease in weight in one month (4.5% change in usual body weight). The 12/11/2025 weight was 112.8 pounds. The recent weight trends were as follows: 06/2025 weight: 120.2 pounds, 09/05/2025 weight: 121 pounds, and 11/07/2025 weight: 118.2 pounds.The Dietary Progress Note dated 12/15/2025, written by Registered Dietitian #1, documented: Weekly weight available (today)- 112.2 pounds, which is consistent with the monthly weight of 112.8 pounds that was taken on 12/11/2025. The resident triggered significant weight loss (5%) this month.During an interview on 01/16/2026 12:30 PM, Registered Dietitian #1 stated the resident's weight on 12/29/2025 was 104 pounds, which they never entered into the electronic medical record because it reflected an 8.2 pounds weight loss since 12/15/2025 and wanted a reweight. Registered Dietitian #1 stated they requested a reweigh of the resident to confirm the accuracy of the 104 pound weight; however, there was never any weight taken for resident after 12/29/2025. During an interview on 01/16/2026 at 1:00 PM, Registered Dietitian #1 stated they did not notify the Physician of Resident #84's significant weight loss because they were waiting for the resident to be reweighed. During an interview on 01/16/2026 at 2:50 PM, Registered Nurse #2 stated they did not know that Resident #84 had a significant weight loss, otherwise they would have notified the Physician of the weight loss for further work up. During an interview on 01/20/2026 at 1:05 PM, the Medical Director stated when a resident has a significant weight loss, the resident's Primary Physician/Medical Provider should be notified by the Registered Dietitian or the Unit Nurse. 10 NYCRR 415.3(f)(2)(ii)(b)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review (Incident # 2677700), the facility did not ensure each covered individual report immediately, but not later than two (2) hours, to the administration of the facility and to the New York State Department of Health after the allegation was made. This was identified for one (1) (Resident #116) of two (2) residents reviewed for Abuse. Specifically, on 11/23/2025 at 2:00 AM, Resident #116 reported a verbal abuse allegation to Licensed Practical Nurse #5. Registered Nurse #2 was made aware of the abuse allegation and did not report the incident to the facility administration until 11/24/2025, 24 hours after the allegation was made.The finding is:The facility's policy titled Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident's Property, last reviewed 06/22/2018, documented verbal abuse as any use of oral, gestured or written languages which uses degrading or derogatory terms towards residents. Mental abuse is defined as but not limited to harassment which was threats of punishment, mental anguish or mental illness. Section six (6) of the policy on reporting documented that the Director of Nursing Services or designee is responsible for reporting all alleged violations and all substantiated incident to the New York State Department of Health and to all other agencies as required. The policy did not indicate specific timeframes to for all reportable incidents including but not limited to allegation of abuse, suspicion of crime, and serious/non serious injuries.Resident #116 was admitted with diagnoses that included fracture of the left ulna (one of two long bones in the forearm), fracture of the left humerus (one of two long bones in the forearm) and multiple fractures of the ribs (curved bones that round from the back to the chest). The admission Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 14, which indicated the resident had intact cognition. The resident exhibited no behavioral symptoms at the time of the assessment.The Comprehensive Care Plan for Abuse dated 11/17/2025 documented Resident #116 was at risk for abuse and neglect. Interventions included to observe resident for unusual skin marks, discoloration, ecchymosis and report promptly, to investigate accident as needed (PRN) and to in-service staff on abuse and neglect.The Comprehensive Care Plan for Behavioral Symptoms related to Fabrication/Accusatory Behavior dated 12/01/2025 documented Resident #116 exhibited verbal behavioral symptoms related to fabricating and accusing others. The behavioral symptoms are noted to put the resident at significant risk for physical illness or injury. Interventions included to assess for unrecognized need and preferences, to separate from others when agitated. The care plan did not document specific dates and events of accusatory behaviors.A review of the facility's Accident and Incident Report dated 11/23/2025 documented that on 11/23/2025 at approximately 2:00 AM Resident #116 reported to Licensed Practical Nurse # 5 that someone wanted to hurt their arm. Licensed Practical Nurse # 5 reported the allegation to Registered Nurse #2. Registered Nurse # 2 initiated the Accident and Incident report. The Assistant Director of Nursing Services signed for the Director of Nursing Services on 11/24/2025 and notified the New York State Department of Health.A written statement by Licensed Practical Nurse # 5 dated 11/25/2025 documented that during the 11/22/2025 to 11/23/2025 overnight shift, Resident #116 reported that an aide from the previous shift made a statement about breaking the resident's already injured hand. The resident expressed fear regarding this comment. Licensed Practical Nurse # 5 provided assurance of safety and reported the allegation to the Registered Nurse supervisor immediately.A statement from Resident #116, written by the Assistant Director of Nursing Services, dated 11/24/2025 documented that the incident occurred between 3:00 PM to 4:00 PM on Saturday (11/22/2025). Resident #116 stated they had an argument with a person with a red wig whom Resident #116 had seen on the unit before. Resident #116 said something derogatory to this person, and the discussion escalated into an argument. Resident #116 stated that the person grabbed their arm and said, let me break your arm again and see how you like it. Resident #116 did not identify the (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	person by name.The undated investigative summary, written by the Assistant Director of Nursing Services, documented that on the morning of 11/24/2025 they were notified by the Unit Manager/Supervisor that on Sunday 11/23/2025 at approximately 2:00 AM, Resident #116 reported that a short [in stature] Certified Nursing Assistant with a red wig told Resident #116 that they will hurt the resident's arm even more after Resident #116 used slur words towards the Certified Nursing Assistant. Law enforcement and the New York State Department of Health were notified. The alleged perpetrator (Certified Nursing Assistant #6) was removed from the schedule. The facility concluded there was no cause to believe abuse occurred.The Nursing Home Facility Incident Report documented the abuse allegation was submitted to the New York State Department of Health on 11/24/2025 at 4:55 PM.A review of Resident #116's medical record indicated there was no documented evidence about the abuse allegation made by Resident #116.Resident #116 was discharged from the facility on 12/27/2025 and was unavailable for interview and observation.During an interview on 01/15/2026 at 11:17 AM, Licensed Practical Nurse #5, who reported the allegation on 11/23/2025, stated that they reported the allegation made by Resident #116 to Registered Nurse # 2 immediately. Licensed Practical Nurse # 5 stated that they did not recall any details of the incident at this time.During an interview on 01/15/2026 at 12:03 PM, Registered Nurse # 2, who was the nursing supervisor on 11/23/2025 during the night shift (11:00 PM-7:00 AM), stated Licensed Practical Nurse # 5 reported to them (Registered Nurse # 2) of Resident #116's allegation of abuse around 2:00 AM on 11/23/2025. Registered Nurse # 2 stated that they immediately interviewed Resident #116 who stated that a staff member from the previous shift (3:00 PM-11:00 PM) verbally threatened to hurt their (Resident #116) arm after Resident #116 and the staff member got into an argument. Registered Nurse # 2 stated that Resident #116 denied being physically hurt. Registered Nurse # 2 stated that they did not immediately report the incident to the Director of Nursing Services or the Assistant Director of Nursing Services because they were focused on ensuring the resident's wellbeing and that the alleged perpetrator was not assigned to the resident anymore. Registered Nurse # 2 stated that they notified the Assistant Director of Nursing Services on the morning of 11/24/2025 which was more than 24 hours after the allegation was brought to their attention. Registered Nurse # 2 stated they should have reported Resident #116's abuse allegation to the Director of Nursing Services or the Assistant Director of Nursing Services but it went over my head.During an interview on 01/15/2026 at 12:32 PM, Certified Nursing Assistant #6, who was Resident #116's assigned Certified Nursing Assistant on 11/22/2025 during the evening shift (3:00 PM-11:00 PM), stated that they did not get into any argument with Resident #116 during the shift. Certified Nursing Assistant #6 stated Resident #116 did not use derogatory language towards them. Certified Nursing Assistant #6 stated they provided all care to Resident #116 that evening when the resident was in bed and did not encounter the resident in the bathroom at 4:00 PM on 11/22/2025. Certified Nursing Assistant #6 stated that they did not verbally threaten to make resident's injured hand hurt more and they did not physically hurt the resident.During an interview on 01/15/2026 at 01:54 PM, the Assistant Director of Nursing Services stated Registered Nurse # 2 should have immediately notified them or the Director of Nursing Services to seek guidance on how to proceed with the investigation. The Assistant Director of Nursing Services stated they were made aware of the incident on Monday (11/24/2025) morning. The Assistant Director of Nursing Services stated they did not report the incident to New York State Department of Health within two hours because they only needed to report incident that resulted in serious harm within two hours and had four (4) to 24 hours to report any abuse and neglect incident without serious injury. The Assistant Director of Nursing Services stated they were not aware that all alleged abuse must be reported within two hours after the allegation was made.During an interview on 01/15/2026 at 03:01 PM, the Director of Nursing Services stated they were on vacation and were not involved in the reporting and investigating of the incident for Resident #116. The Director of Nursing Services stated that Registered Nurse # 2 should have contacted either the Administrator, the Director of Nursing Services, or the Assistant Director of Nursing Services immediately when the incident was (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	first reported. The Director of Nursing Services stated any abuse or neglect allegation with visible injury must be reported to the New York State Department of Health and law enforcement within an hour and those that did not result in injuries must be reported to the New York State Department of Health within four (4) to 24 hours. The Director of Nursing Services stated they were not aware that all alleged abuse must be reported within two hours after the allegation was made regardless of absence of physical injuries. The Director of Nursing Services stated that they were involved in developing and reviewing the facility's Abuse policy and the policy did not include reporting timeframe requirements for all reportable incidents.During an interview on 01/15/2026 at 03:32 PM, the Administrator stated Resident #116's allegation of abuse should have been reported immediately to the Director of Nursing Services or the Assistant Director of Nursing Services on 11/23/2025 and reported to the New York State Department of Health within two hours after the abuse allegation was made. The Administrator stated that they were involved in developing and reviewing the facility's Abuse policy and the policy did not include reporting timeframe requirements for all reportable incidents. The Administrator stated that the policy should have included the timeframe requirements for all reportable incidents.During an interview on 01/20/2025 at 03:40 PM, the Medical Director stated they were involved in developing and reviewing the facility's Abuse policy. The Medical Director stated that current facility policy on Abuse did not include reporting timeframe requirements for all reportable incidents. The Medical Director stated that they expected all abuse allegations to be reported to the New York State Department of Health immediately but did not know the specific timeframe that was required for abuse allegations or for all other reportable incidents.10 NYCRR 415.4(b)(2)

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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, the facility did not ensure that a comprehensive person-centered care plan was implemented to meet each resident's medical and nursing needs. This was identified for one (1) (Resident #37) of two (2) residents reviewed for Position and Mobility. Specifically, Resident #37 required use of a pillow for the lower extremities to prevent direct contact of the boney prominences (knees) due to contractures as per the resident's plan of care. On multiple observations, the resident was observed without the use of the pillow in between the knees.The finding is:The facility policy titled Management and Treatment of Pressure Ulcers dated 12/2024 documented interventions to use devices, such as pillows and foam wedges to prevent direct contact between bony prominences and consult with the Physical Therapist for the positioning devices.The facility policy titled Assistive/Adaptive and Preventative/Positioning Devices dated 02/2025 documented a knee separator to be used to prevent knee contractures and maintain skin integrity. The use of preventative/positioning devices will be indicated in the Comprehensive Care Plan and on the Certified Nursing Assistant accountability record.Resident #37 was admitted with diagnoses that included metabolic encephalopathy (brain dysfunction caused by a chemical imbalance leading to confusion, memory problems or coma), major depressive disorder (mood disorder causing sadness, loss of interest and impacts daily functioning), and type 2 diabetes mellitus (a condition where the body has too much sugar in the blood). The Quarterly Minimum Data Set assessment dated [DATE], documented that Brief Interview for Mental Status score could not be completed as the resident was rarely/never understood. The Quarterly Minimum Data Set assessment documented Resident #37 had limitations in range of motion to their lower extremities bilaterally (both sides). A Comprehensive Care Plan for Activities of Daily Living dated 01/23/2025 last revised on 01/12/2026 documented interventions that included to place a pillow between the lower extremities in and out of bed.The Resident Nursing Instructions (resident care instructions for Certified Nursing Assistant) effective 05/14/2025, documented to place a pillow in between the lower extremities in and out of bed.A rehabilitation screening form dated 12/29/2025 documented Resident #37 had significant bilateral hip and knee contractures.A physical therapist note dated 01/09/2026 documented Resident #37 had severe fixed bilateral lower extremity contractures with limited range of motion. The knee abduction wedge was not tolerated and the Physical Therapist recommended to use a pillow in between the lower extremities.During an observation on 01/13/2026 at 1:15 PM, Resident #37 was in a Geri chair in their room. Both legs were noted to be contracted. There was no pillow or cushion in between the resident's knees. During an observation on 01/15/2026 at 7:34 AM, Resident #37 was in a Geri chair in their room. Both legs were noted to be contracted. There was no pillow or cushion in between the resident's knees. During an observation on 01/16/2026 at 7:40 AM, Resident #37 was in bed. There was no pillow in between the resident's knees, and no pillow was seen lying around the bed or on the floor. During an interview and observation on 01/16/2026 at 09:58 AM, the 7:00 AM-3:00 PM shift Certified Nursing Assistant #1 stated Resident #37 had a habit of pulling the pillow out from their knees. Certified Nursing Assistant #1 stated they would replace the pillow and would notify the nurses about the resident's behavior. Certified Nursing Assistant #1 then went into Resident #37's room. The resident was observed in bed with no pillow in between their legs. Certified Nursing Assistant #1 stated they checked the resident this morning during their morning rounds and thought the pillow was placed in between the resident's legs.During an interview on 01/16/2026 at 10:06 AM, Registered Nurse Unit Manager #1 stated they knew that Resident #37 had a behavior of pulling the pillow out. Registered Nurse Unit Manager #1 stated they did not document the resident's behavior and did not update the resident's care plan.During an interview on 01/20/2026 at 12:24 PM, the Director of Nursing Services stated the resident's plan of care should have been followed. The use of (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the pillow for Resident #37 was for comfort and to prevent the contracted knees from rubbing together and causing a pressure ulcer. 10 NYCRR 415.11(c)(1)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility did not ensure the resident maintained, to the extent possible, acceptable parameters of nutritional and hydration status. This was identified for one (1) (Resident #84) of two (2) residents reviewed for Nutrition. Specifically, on 12/11/2025, Registered Dietitian #1 documented Resident #84 as having a weight loss of 5.4 pounds in one-month (a 4.5% decrease in the resident's usual body weight) and recommended weekly weights for four (4) weeks to further assess the accuracy of the resident's weight trends. On 12/15/2025, Registered Dietitian #1 documented Resident #84 triggered for an undesired significant weight loss (5% in one month). The weekly weights were not completed as per the recommendations, and no new dietary interventions were put in place. On 1/16/2026, Resident #84's weight reflected an additional loss of 4 pounds (3.57%) in one month and an undesired significant weight loss of 10.2% in 3 months. The finding is: The facility's policy titled, Significant Weight Change, last reviewed 11/25/2025, documented the Clinical/Registered Dietitian will track and evaluate resident weights on a monthly basis. All residents with a significant weight change greater than 5% in one (1) month, 7.5% in three (3) months, or 10% in six (6) months will be reviewed by the Clinical/Registered Dietitian. The Clinical/Registered Dietitian will use clinical judgement with assessing weight loss and may, including, but not limited to, monitor weekly weights and follow up with all interventions/recommendations as needed. Resident #84 had diagnoses that included hypertension (abnormally high blood pressure) and type 2 diabetes mellitus (a form of diabetes mellitus characterized by high blood sugar, insulin resistance, and lack of insulin). The Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented the resident had severely impaired cognitive skills for daily decision making with long and short term memory problems. The Minimum Data Set documented the resident's height was 63 inches and the weight was 121 pounds. The resident had no weight loss of 5% or more in the last month or a loss of 10% of more in the last six (6) months and was not on a physician-prescribed weight-loss regimen. The Physician's Order dated 07/03/2024 and last renewed on 01/19/2026 documented for the resident to receive a no added salt, low concentrated sweets diet and a thin liquid consistency.The Physician's Order dated 07/11/2024 and last renewed on 01/19/2026 documented for the resident to receive mechanical soft food consistency.The Physician's Order dated 09/05/2025 and last renewed on 12/22/2025 documented for the resident to receive Boost Glucose Control 0.07 gram-0.8 kilocalorie/milliliter oral liquid (a nutritional supplement) 240 milliliters by oral route once daily. This order was discontinued on 01/16/2026.The Dietary Progress Note dated 12/11/2025, written by Registered Dietitian #1, documented: Resident noted with a 5.4 pounds decrease in weight in one month (4.5% change in usual body weight). The 12/11/2025 weight was 112.8 pounds. The recent weight trends were as follows: 06/2025 weight: 120.2 pounds, 09/05/2025 weight: 121 pounds, and 11/07/2025 weight: 118.2 pounds. Registered Dietitian #1 recommended weekly weights for four (4) weeks to further assess accuracy of the weights.The Comprehensive Care Plan entitled Nutritional Status, initiated on 07/05/2024, documented as an intervention including obtaining weekly weights for four (4) weeks. The weekly weight intervention was initiated on 12/11/2025.The Dietary Progress Note dated 12/15/2025, written by Registered Dietitian #1, documented: Weekly weight available (today) of 112.2 pounds. Consistent with monthly weight of 112.8 pounds taken on 12/11/2025. The resident triggered for a significant weight loss (5%) this month and weekly weights were in progress. Review of the Weight Monitoring in the electronic medical record on 01/16/2026 at 11:25 AM revealed no documented evidence of the resident being weighed since 12/15/2025.During an interview on 01/16/2025 at 11:40 AM, Registered Dietitian #1 stated the last weight they had gotten for the resident was 104 pounds on 12/29/2025 which they had not entered into the resident's electronic medical record because it had been over an eight (8) pound weight loss since the resident's last weight of 112.2 pounds taken on 12/15/2025. Registered Dietitian #1 stated before they documented (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ross Center for Nursing and Rehabilitation	839 Suffolk Avenue Brentwood, NY 11717

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident's weight in the electronic medical record, they requested a reweight from Registered Nurse #2; however, the weight was never obtained. During an observation on 01/16/2026 at 11:45 AM Registered Nurse #2 and Certified Nursing Assistant #3 weighed Resident #84. The resident's weight was recorded as108.2 pounds. During an interview on 01/16/2026 at 1:00 PM, Registered Dietitian #1 stated they were not aware if the facility had a policy to address significant weight loss. Registered Dietitian #1 stated if a resident on their unit had a significant weight loss, they would verbally tell the Registered Nurse Unit Managers about the weight loss and also discuss it in morning report. Registered Dietitian #1 stated they could not recall if they had discussed Resident #84's significant weight loss in morning report. They had requested the weekly weights for Resident #84 from Registered Nurse #2; however, the weekly weights were not completed. Registered Dietician #1 stated they did not notify the Physician of Resident #84's significant weight loss because they were waiting for the resident to be reweighed. During an interview on 01/16/2026 at 2:50 PM, Registered Nurse #2 stated they were aware the resident was supposed to be weighed weekly. Registered Nurse #2 stated Registered Dietitian #1 requested the resident to be reweighed; however, the resident was not reweighed because the nursing unit staff did not obtain the weight. Registered Nurse #2 stated the nursing staff should have obtained the resident's weekly weight and reweighed the resident when requested by the Dietician. Registered Nurse #2 stated they were not aware that the resident had a significant weight loss, otherwise they would have notified the Physician of the weight loss for further interventions and work up. The Physician's Order dated 01/16/2026, written by Physician Assistant #1, documented to increase Boost Glucose Control 0.07 gram-0.8 kilocalorie/milliliter oral liquid (a nutritional supplement) to 240 milliliters by oral route two (2) times per day for unspecified protein-calorie malnutrition.During an interview on 01/20/2026 at 1:05 PM, the Medical Director stated when a resident has a significant weight loss, the resident's Primary Physician/Medical Provider should be notified by the Registered Dietitian or the Unit Nurse. The Primary Physician/Medical Provider would assess the resident, review the resident's weight trend, consider ordering oral nutritional supplementation, and possibly order a calorie count. During an interview on 01/20/2026 at 4:05 PM, the Director of Nursing Services stated Registered Dietitian #1 should have reported difficulties obtaining the resident's weekly weights. The Director of Nursing Services stated weights should be obtained the same day they were requested. The Director of Nursing Services stated once a month a Weight Loss Meeting is held to determine the cause of the residents' weight loss and the residents' Physicians are notified to see if they want to order any blood work for the resident and order weekly weights if appropriate. The monthly weight loss meeting was not conducted in December 2025, because they were on vacation. The Director of Nursing Services stated Registered Dietitian #1 had only been working at the facility for a few weeks and were not informed about the monthly Weight Loss Meeting. The Director of Nursing Services stated the facility did have a policy addressing Significant Weight Changes and was unsure why Registered Dietitian #1 was not aware of that. 10 NYCRR 415.12(i)(1)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. Based on observations, record review, and interviews the facility did not ensure that parenteral fluids were administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This was identified for one (1) (Resident #117) of one (1) resident reviewed for Antibiotics. Specifically, Resident #117 had a physician's order to infuse Ceftriaxone (antibiotic) medication; however, the route of infusion was not specified in the order. During multiple occasions, Resident #117 was observed with a Peripheral Intravenous Catheter in their left hand. There was no physician's order for the assessment and care of the intravenous catheter.The finding is: The facility policy titled initiation and management of intravenous therapy revised on 10/2025 documented a valid order from a licensed practitioner for Intravenous fluids authorizes nursing staff to initiate peripheral access as necessary to carry out the prescribed treatment. A separate order for peripheral intravenous insertion is not required, unless otherwise specified by facility policy or the type of vascular access. Resident #117 was admitted with diagnoses including urinary tract infection, metabolic encephalopathy, and dementia. The Minimum Data Set assessment documented the resident had severely impaired cognition. The Minimum Data Set was not completed and did not include information regarding intravenous antibiotic use as the resident was recently admitted to the facility. The care plan for Urinary Tract Infection dated 01/12/2026 documented interventions including to administer medications as ordered, maintain infection control practices through proper handwashing, monitor for signs and symptoms of side effects of antibiotics. The physician's order initiated on 01/12/2026 documented Ceftriaxone 1Gram /100 milliliter normal saline, infuse 1 gram once daily every day at 9:00 AM for seven (7) Days for Urinary tract infection. The order did not include the route of the medication administration. A review of the medical record revealed there were no physician orders and documentation that care and monitoring for signs and symptoms of infection of the intravenous site was provided. During the screening observation on 1/13/2026 approximately 11:00 AM, the resident was in their bed with an intravenous catheter in the left forearm. There was no medication being infused via the intravenous catheter.During an observation on 1/14/2025 at approximately 9:00 AM, Resident #117 was observed in bed with an intravenous catheter in their right arm. The resident was receiving an intravenous antibiotic medication. During the interview on 01/15/2026 at 08:23 AM, Licensed Practical Nurse#3 stated that all intravenous medications must have order for intravenous line access. Licensed Practical Nurse #3 stated the Registered Nurse supervisor was responsible for entering the physician's order and inserting intravenous access sites. Licensed Practical Nurse#3 stated they did not realize there were no physician orders for flushing the Intravenous line and monitoring the site for signs and symptoms of infection. Licensed Practical Nurse#3 stated they flush all intravenous lines sites before and after they administer the medications to make sure the Intravenous line is patent and functioning. During an interview on 01/15/2026 at 08:33 AM, Registered Nurse Unit Manager#3 stated residents who receive intravenous medications must have a physician's order for inserting the intravenous access line, flushing the line with normal saline, and to check the site for signs and symptoms of infection. Registered Nurse Unit Manager#3 stated they did not realize there were no physician orders for the insertion of the intravenous line access and its maintenance. Registered Nurse Unit Manager#3 stated it was the admission Nurse and the Unit Manager's responsibility to enter the physician's orders in the resident's medical record. During an interview on 01/15/2026 at 09:54 AM, Registered Nurse Supervisor #4 stated on 01/12/2026 they completed the admission assessment for Resident #117. Registered Nurse Supervisor #4 stated they reviewed the hospital discharge medications and obtained the physician's orders from Physician Assistant #1. Resident #117 required Intravenous antibiotic infusion for a Urinary Tract Infection. Registered Nurse Supervisor #4 stated they inserted the intravenous line access, flushed the line with normal saline to maintain the patency, and monitored the intravenous (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	site for skin integrity but they forgot to initiate the orders on 01/12/2026. During an interview on 01/15/2026 at 10:15 AM, Physician Assistant #1 stated the admission nurse called them on the night of 01/12/2026 and reviewed Resident #117's hospital discharge medications. Physician Assistant #1 stated there was no need for separate orders for the insertion of the intravenous line access or routine care and monitoring because it is implied, and the nurses automatically know that it should be done. Physician Assistant #1 stated the initiation of the intravenous line is the nurses' responsibility and they assume that nurses know to flush and monitor the intravenous line. During an interview on 01/20/2026 at 11:36 AM, the Medical Director stated the physician's order for intravenous infusion of antibiotics implies that there is an intravenous access line; therefore, there is no need for a separate physician's order to insert the intravenous access line. The Medical Director stated the intravenous line should be flushed with normal saline to maintain the patency and integrity of the line. The intravenous line site should be monitored for signs and symptoms of infection and infiltration. The Medical Director stated they assumed the nurses were doing the care without a physician's order and there was no need for physician orders. The Medical Director stated they were not aware of the regulatory requirements for parenteral fluids. During an interview on 01/20/2026 at 12:34 PM, the Director of Nursing Services stated separate physician's orders for intravenous line access, flushing the line with normal saline and monitoring the site for signs and symptoms of infection are not needed because the tasks should be included in the physician's order for intravenous medication. The Director of Nursing Services stated the facility's policy indicated that the nursing staff do not need a physician's order for intravenous line access. 10 NYCRR 415.12(k)(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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility did not ensure that residents were assisted in obtaining routine Dental Care. This was identified for one (1) (Resident #5) of one (1) resident reviewed for dental care. Specifically, Resident #5 was not seen by a Dentist since their admission to the facility in June 2024. The finding is:The facility's policy titled, Dental Services, last reviewed 10/2025, documented residents will be seen and evaluated by the Dentist upon admission, annually, as requested by the resident and/or representative, and as needed with a significant change of condition. The policy did not state if a physician's order was required for a resident to be seen by a Dentist.Resident #5 had diagnoses which included hypertension (abnormally high blood pressure) and type 2 diabetes mellitus (a form of diabetes mellitus characterized by high blood sugar, insulin resistance, and lack of insulin). The 5-Day Minimum Data Set (MDS) assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognitive skills for daily decision making. The resident had no broken or loose fitting full or partial denture and no mouth or facial pain, discomfort, or difficulty with chewing.During an interview on 01/13/2026 at 11:15 AM, Resident #5 stated they had dentures in the community. Resident #5 stated when they came to the facility, they did not have their upper and lower dentures, and they were never seen by a Dentist since being admitted to the facility. Resident #5 stated they would like to have their dentures replaced.A review of the resident's medical record revealed no documented evidence that the resident was ever seen by a Dentist.The physician's order dated 01/16/2026 documented for the resident to have a Dental Consultation in house, as needed.During an interview on 01/20/2026 at 11:35 AM, the Assistant Director of Nursing Services stated they did not know why Resident #5 was never seen by a Dentist since being admitted to the facility. The Assistant Director of Nursing Services stated the resident was originally admitted to the facility as a short-term rehabilitation resident and then became a long-term care resident at which time the resident should have been seen by a Dentist. During an interview on 01/20/2026 at 1:20 PM, Registered Nurse #2 stated all consultations, including consultations by the Dentist, require a physician's order. Registered Nurse #2 stated they had obtained a physician's order on 01/16/2026 when they realized the resident was never seen by a Dentist. Registered Nurse #2 stated they keep a list to keep track of when each resident's annual Dental examination is due; however, Resident #5 was not on their list because they were never seen by a Dentist. During an interview on 01/20/2026 at 3:50 PM, the Medical Director stated a physician's order is required for a dental consult and that should have been documented in the facility's Dental Policy. During an interview on 01/20/2026 at 4:20 PM, the Director of Nursing Services stated that Resident #5 was never seen by a Dentist, and it was an oversight. The Director of Nursing Services stated they will reevaluate the facility's Dental policy to address the need for a physician's order for a dental consultation.10 NYCRR 415.17(a-d)

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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 observation, record review, and interviews the facility did not ensure that it maintained an infection prevention and control program designed to help prevent the development and transmission of infectious diseases. This was identified for one (1) (Resident #88) of six (6) residents reviewed for Medication Administration Task. Specifically, during the medication administration task, Licensed Practical Nurse #1 removed a calcium /vitamin D3 tablet (vitamin supplement) from a blister pack with their bare hands. Licensed Practical Nurse #1 broke the tablet in half and put the two halves of the tablet in the souffle cup and proceeded to offer the medication to Resident #88.The finding is:The facility policy titled Medication Administration last reviewed/revised 12/2025, documented pills should not be handled with fingers. Pour directly from blister packs into souffle cup.Resident #88 was admitted with diagnoses that included Parkinson's disease (a progressive brain disorder that damages neurons leading to problems with movement), congestive heart failure (the heart muscle does not pump blood effectively), and dementia (decline in mental abilities). The Quarterly Minimum Data Set assessment dated [DATE], documented a Brief Interview for Mental Status score of 12, indicating the resident had moderate cognitive impairment.A physician's order dated 07/11/2025 and last renewed on 12/10/2025 documented calcium 315 milligram/vitamin D3 6.25 microgram tablet, give one tablet by oral route once daily for deficiency in vitamins.During an observation of the Medication Administration Task on 01/15/2026 at 8:50 AM, Licensed Practical Nurse #1 removed the calcium 315 milligram-vitamin D3, 6.25 microgram tablet, from the blister pack with their bare hands. Licensed Practical Nurse #1 then broke the tablet in half and placed the two halves in a souffle cup. Licensed Practical Nurse #1 then proceeded to administer the same medication to Resident #88. During an interview on 01/15/2026 at 8:53 AM, Licensed Practical Nurse #1 stated they should have put on gloves and should not have touched the medication tablet with bare hands. Licensed Practical Nurse #1 stated the calcium tablet was a large pill and not easy to swallow so they wanted to break the tablet in half to make it easy for the resident to swallow.During an interview on 01/15/2026 at 9:14 AM, Registered Nurse Unit Manager #1 stated the medication nurse should not have handled any medications with bare hands. If they needed to break or crush a medication, they should have put on gloves or put the tablet in a tablet bag to crush the medication. Registered Nurse Unit Manager #1 stated that handling medications with bare hands is an infection control concern.During an interview on 01/15/2026 at 2:58 PM, the Director of Nursing Services stated the nurses should wear gloves when handling medications. The Director of Nursing Services stated to prevent contamination and spread of infections; the nurses must not handle the medication tablets with their bare hands.10 NYCRR 415.19(a)(1-3)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews the facility did not ensure call systems were accessible to each resident while residents were in their rooms. This was identified for one (1) (Resident #57) of one (1) resident reviewed for call systems. Specifically, during multiple observations, Resident #57 was observed in bed, and the call bell was out of their reach.The finding is:The facility policy titled Call Bells last revised on 12/2025, documented to have a call bell at the bedside within reach. The purpose of the call bell is to provide the resident with a method of communication to assist in meeting needs in a timely manner.Resident #57 was admitted with diagnoses that included cerebral infarction (brain tissue dies due to lack of blood, oxygen, and nutrients), dementia (a decline in thinking skills due to damaged blood vessels in the brain), and epilepsy (a neurological disorder that causes seizures, loss of consciousness and unusual behavior). Minimum Data Set assessment dated [DATE], documented that a Brief Interview for Mental Status score could not be completed as the resident was rarely/never understood. The Minimum Data Set assessment documented Resident #57 was dependent on staff for activities of daily living.The Comprehensive Care Plan, titled Falls: at risk for falls, dated 04/11/2022, and last reviewed and revised 12/15/2025, documented interventions that included to place the call bell within reach at all times.During an observation on 01/13/2026 at 10:11 AM, Resident #57 was observed in their room, in bed sleeping. The call bell was observed hanging on the wall and was out of the resident's reach.During an observation on and on 01/13/2026 at 1:08 PM, Resident #57 was observed in their room, in bed resting. The call bell was observed hanging on the wall and was out of the resident's reach.During an observation on 01/20/2026 at 7:01 AM, Resident #57 was observed in their room, in bed awake. The resident was not interviewable. The call bell was observed on the floor, behind the nights stand, and was out of the resident's reach. During an interview and observation on 01/20/2026 at 7:06 AM, Licensed Practical Nurse #2 stated the call bell should be within the resident's reach. The Certified Nursing Assistants should check on the placement when they are doing their rounds. Licensed Practical Nurse #2 stated Resident #57 could use the call bell to call for assistance. Resident #57's call bell was observed on the floor, behind the nightstand. Licensed Practical Nurse #2 picked up the call bell, wiped it clean, and clipped the call bell onto the bed cover, within the resident's reach.During an interview on 01/20/2026 at 7:10 AM, Registered Nurse Unit Manager #1 stated the Certified Nursing Assistants, and the nurses were responsible to ensure the call bell is within reach of the resident. The 11:00 PM-7:00 AM shift Certified Nursing Assistants should have made rounds before leaving this morning and should have seen the call bell was out of reach. During an interview on 01/20/2026 at 12:26 PM the Director of Nursing Services stated the Certified Nursing Assistants, Licensed Practical Nurses, and the Nurse Supervisors are responsible to ensure that each resident has a call bell within reach to ensure that the resident could call staff for assistance. 10 NYCRR 415.29